

# PHILADELPHIA MEDICAL TIMES.

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## CLINICAL LECTURE.

HÔPITAL DE LA PITIÈ, PARIS.

PROFESSOR JACCOUD,

### ON THE TREATMENT OF TY- PHOID FEVER.

(Translated by Thomas Linn, M.D., Paris).

GENTLEMEN: Those among you who follow my service constantly have no doubt noticed that I put typhoid fever patients under a form of treatment that is somewhat complex, but it is always the same and uniform in character, although some of the means used are variable; but these last are not always used, as they are subject to certain conditions that I will explain more exactly after I have first given you my regular or constant treatment.

The moment the diagnosis is certainly made, I invariably place the patient on a fixed regimen which consists of one and a-half to two quarts of milk per day, and this is the fundamental agent of the system. You must never forget that one of the essential and constant dangers in typhoid fever is urinary insufficiency, both in quantity and quality. By the administration at once of milk, I assure as far as I can, a proper uresis. You will have no trouble in getting these patients to take milk;

they gladly accept any fluids, even those who dislike milk when well will readily take a quart the first day, and get up to two in a few days. You may also add a little soup to this diet, and in all cases give at least a half pint of good wine every twenty-four hours (Bordeaux claret used here). This give pure or mixed in a little water, and in several doses, but always the full quantity of wine every day.

Next to this I use the *antithermic* methods. I say the antithermic, and not the antipyretic, as the first acts by *subtracting* a certain quantity of caloric from the patient, while the last acts on the production of the heat itself. I employ cold lotions of aromatic vinegar, and have two of them applied if the evening temperature is not over 39° centigrade. If it goes to 39.5° I use six lotions, and if it rises to 40° and *a fortiori* over, I have eight applied; that is to say one every three hours. This causes a fall of temperature varying from 0.7° to one degree after each application, and this lasts from half an hour to an hour. The result is that this temporary refrigeration, often repeated, will sometimes become permanent or antipyretic. But I only wish to impress you with its antithermic effects. These lotions are used from the first and are continued on into

the convalescent period. Besides this I use *stimulation*. From the first day these patients take some form of alcohol, rum, brandy, etc., whatever they find the most agreeable or least disagreeable. I give at first 40 grammes, and where the dynamic phenomena are intense, I raise the dose to 60, 70 and 80 grammes in twenty-four hours. I put this in the form of a cordial, adding four grammes of cinchona extract to it, and during the last half of the malady, I put in from 4 to 7 grammes of acetate of ammonia. This cordial may be slightly varied to suit the taste of different patients, by adding such flavoring matter as is desired, but the plain form is best when well taken. Should bronchial or broncho-pulmonary catarrh be intense during the thoracic symptoms, I have applied on the inferior members at least 40 dry cups, repeating this for six to eight days, according to the case.

This is the whole of my uniform treatment in a large majority of cases, so that if there are no bronchial symptoms you can readily put it in one line, *milk, wine, cold lotions, and the alcoholic potion*.

Now, what is my variable treatment? Well, first of all, it is not a modification of the regular system used, which always remains the same. Whatever else I introduce the fundamental treatment described remains fixed and the rest is added to it. I use then in addition sometimes antipyretic medication, that is to say quinine and salicylic acid and another agent of which I will speak later on, this is digitalis. First as to quinine and salicylic, these I use when the fever is not subdued by several days of cold lotions and is *serious*. You will ask me, when is a fever serious? You must *not* judge of the gravity of fever by the vesperal or evening temperature and believe that a high evening temperature is a sign of a dangerous fever. It of itself means nothing at all. If there is a series of high evening temperatures it is more important, say  $40.5^{\circ}$  to  $41^{\circ}$  for several days; but your real and only true guide is the *remissions*; a fever relatively weak, if it has very weak remissions, is more serious for the organism than a fever that may have high vesperal tem-

peratures and strong morning remissions. In the last case, the body rests more and is not *constantly* under a maximum of combustion. But how are you to judge that the remission is sufficient? So that the fever of itself shall not be a serious danger, the principle, gentlemen, is an infallible one. *The remissions must be equal to the diurnal oscillation of the temperature*. If the fever does not present daily remissions at least equal to the oscillation, the fever is serious of itself and must be treated.

The diurnal oscillation of physiological temperature is from  $0.8^{\circ}$  to  $1^{\circ}$ , and if a fever presents remissions equal to this it has no intrinsic gravity, and I only use the regular treatment as described; but when the remissions are less, for instance only  $0.5^{\circ}$ , and the more so when the line approaches the level, then I give, as a rule, quinine. I consider the salicylic acid better in this malady; but I am not always free to give it owing to the contra-indications; so that quinine is the base of my additional treatment. What dose, and how do I use it? First, I never give quinine three days in succession; as a rule only two, and the first day I give the maximum dose, 2 grammes of bi-hydrobromate of quinine, which is equal to 1.50 grammes of sulphate of quinine.

I find this salt to be best borne by the stomach, and when there is cerebral excitation the bromine in it is not to be despised. The full dose of two grammes is given in a hour, in four parts, every quarter of an hour 50 centigrammes, so that there will be accumulation, which cannot be obtained otherwise, owing to the rapid elimination of the quinine; you know that this must be done seven or eight hours before the high temperature is expected, to get the full effect in time. If you wish to modify the evening temperature give it in the morning, and *vice versa*. I never give the same dose the next day; if two grammes are given one day, I give 1.50 the next, and then suspend treatment one to several days, depending on the result obtained; remember that the effect is more marked on the morning temperature than on the evening, as the physiological fall is added.

When I use salicylic acid I give it in the same way; but I told you it had cer-

tain contra-indications, while I am sure it has an equal action on the fever, and it also has a diuretic action, as it is eliminated as salicylic acid; but since I have used milk I don't attach so much importance to this last action, but certainly its antiseptic power is superior to quinine. Then why don't I use it? Because, gentlemen, of its contra-indications, as I said before; they are its renal determination, heart weakness, cerebral accidents, and alcoholism in the patient. Even in rheumatism we have to respect these contra-indications, so much more in typhoid fever, where the heart, kidneys and brain are so often affected; even when there are bronchial troubles it should not be given, as the heart is weakened; but when these contra-indications are not present I prefer salicylic acid to quinine.

In regard to the use of digitalis in typhoid fever, many times, gentlemen, you will find after the second week, even when you have modified the fever and all is doing well, that the pulse will be weak, and if you examine the heart you will find its action is poor, the impulsion feeble, and the sounds, above all the first, very much weakened; in some cases you won't even hear the first sound at all. It is not a pericarditis, nor endocarditis, for if the patient dies you will not find the signs of those troubles, but a weakness of the muscular fibres of the heart structure itself. I treat these symptoms with digitalis, and I am confident that many of these patients owe their lives to its action. It is perhaps useless to tell you that no other medicine is given while using the digitalis, as you know I am not in favor of medicinal warfare by mixtures. I continue the lotions, wine and milk, and the cordial potion, and add an infusion of digitalis, according to the state of the heart and the tolerance of the patient for the drug. I rarely give more than 0. gr. 60 in 24 hours and give less the next day, say 0.40, and if the heart weakens again, I return to the charge.

In all this treatment you have not heard me speak of the diarrhoea you find in typhoid fever; and the reason is that I never try to stop it, and even provoke it when it does not exist. This should not surprise you. You, like myself, must

represent this typhoid process as having its source in the intestines; there must exist there a pullulation of pathogenic germs that, either by themselves or their products, poison the organism and keep up the disease by re-absorption; so therefore let them come away by the natural diarrhoea in these cases. (Professor Peter uses cold water in rectal injections for this purpose.) I prefer to provoke the diarrhoea if it does not continue; on this account I am not a partisan of what is called intestinal antiseptics, as I believe there is no advantage in disinfecting the intestinal matters, if they are evacuated as they should be. It is only the interstitial infiltrations of the innumerable pathogenic agents that are mostly deep in the intestinal mucous membrane and their passage into the mesenteric ganglions, and the spleen that is dangerous. How can antiseptics act against these sources of re-absorption? So that if these matters are eliminated I do not bother about their disinfection, which can only interest the nurses by the smell. But I fear there is great danger in constipation, by closing the door of this natural outlet of poisons, as I find may be caused by *naphthol beta*. Besides I do not know of any cases as yet where the duration of disease has been shortened by intestinal antiseptics nor any statistics showing that it has modified the figures of mortality of typhoid fever. I shall be glad to know that it can be done however, and will hasten to use the method.

#### AMERICAN ASSOCIATION OF GYNÆCOLOGISTS AND OBSTETRICIANS.

##### PRESIDENT'S ADDRESS.

BY WILLIAM H. TAYLOR, M. D.,  
CINCINNATI, OHIO.

**G**ENTLEMEN:—Under the very auspicious circumstances which have attended this meeting I esteem it a high honor to have been made its presiding officer, and I feel it incumbent upon me to express my sense of obligation to you for placing me in this position. At the same time I must say that I appreciate the great responsibility, and have felt the need of your generous consideration in my efforts to discharge its duties.

In thus assembling for the first time as a Society, it may be very proper to demand a reason for its existence. The daily round of professional experience impresses the practitioner of medicine with the fact that there is much yet to learn, and to the man who sees in his avocation something more than a mere source of pecuniary profit—there must arise the desire to know that unknown. No argument is needed to prove the assertion that the united effort of many is more fruitful than the inharmonious working of individuals, hence the propriety of coöperation, *i. e.*, organization.

In the words of an eloquent member of another profession, "It seems very certain that the world is to grow better and richer in the future, not by the magnificent achievements of the highly gifted few, but by the patient faithfulness of the one-talented many." It may be admitted that the motive of our association is first our own advancement, yet it cannot be considered undue self-adulation if we believe that from such combined effort good must come to the profession at large, and, necessarily, through the profession to those who above all others are interested in the perfection of our knowledge and skill—our clients.

The activity of the past decade has given us so many important facts that it would scarcely be hyperbole to say that a new practice of gynecology has been created in that time, and no words of mine can in any full degree express the wonderful benefactions of the recent advances thus made; but the very fact that there has been such progress, and that so much which but a few years ago was impracticable or even unknown is now feasible and well known, only stimulates us to better work and further advance, and with the vast range of study and the diversity of subjects now comprehended by the science of medicine, it is clear beyond controversy that advance can be made only by men directing their effort to a limited field of work.

Such, gentlemen, I believe are sufficient reasons for our presence here today as the American Association of Obstetricians and Gynecologists, and never in the history of our profession

have the auguries been so auspicious for the accomplishment of the purposes set before us, as evinced by the cosmopolitan harmony and close association of our profession in all parts of the world, in the facilities for the speedy transmission of every item of interest, of every discovery and of every suggestion; and more important than all else, by the number of devoted workers who, animated by no unworthy craving for worldly honor or love of gain, are delving into the mysteries of the human frame, scrutinizing every group of asserted facts as the slave does his handful of earth for the diamond. And what matter if the enthusiast does cry out in exultation over what may prove not to be a gem, yet the precious stones of truth that are found abundantly pay for the toil.

While I have felt the great honor of my position, I have also realized the great difficulty of bringing anything before you worthy of your attention, or that may even in a small degree contribute to the success of our organization. The past work of our branch of practice is so recent and so entirely familiar to you that it would be altogether inappropriate to take any time in presenting it. A glance at the programme laid before you will convince you that the various practical topics which are so important are to constitute much of the subject matter for discussion here and, therefore, it is inexpedient for me to dwell upon them now, great as is the temptation so to do.

The proper indications for abdominal section, the true position which electricity shall occupy in gynecology, the propriety of hysterectomy, the value of Alexander's operation and its newly devised congener abdominal fixation for retrodeviations of the uterus, the relative merits of craniotomy, Cæsarean section and induced labor, the best method of dealing with extra uterine pregnancy, the proper means of securing antisepsis, are all questions fraught with great interest and merit the most thorough study, and so confident am I, that before this meeting closes much light will be shed upon many or all of them by your deliberations, that I shall pass them by without further consider-

ation, and having remitted to your care those topics which undoubtedly claim most of your attention and awaken most of your interest, I am constrained to bring before you subjects which may seem of little import; but you will at once agree with me that in the daily routine with most of us, the less important subjects are those which most constantly demand our thought, and assuredly nothing which contributes to the welfare of those who require our care can be too trivial for our study.

Let me now direct your attention to what in my opinion are subjects worthy of our earnest thought, premising my remarks with the statement that the association must not be held responsible for the opinions of any individual, and especially can there be no *ex cathedra* utterances promulgated, but each member must be held accountable for his own sentiments.

So grand have been the results of abdominal section for diseases of women in the hands of skilled men in our own land and abroad that only words of highest commendation are appropriate. These achievements which challenge our admiration and demand the grateful acknowledgment of all who are interested in the mitigation of suffering, are the results of years of toil and conscientious study; but, unhappily, the success is seen while the steps which led to it are overlooked; as a consequence, men without the professional or moral qualifications for such responsible services have been drawn into this line of work till I am sure I am justified in the assertion that to-day laparotomy is done too often and with insufficient grounds for so serious a procedure. Dr. Parvin has recently said, "It cannot be denied that there is a growing belief in the professional mind that these operations are too frequently resorted to, and therefore their indications ought to be clearly established and the presence of the latter conclusively demonstrated before a woman is subjected to what otherwise is an odious mutilation. The results of the operation having been so satisfactory, is there not great danger of such operations being too frequently performed? Nay, is there not danger that men without experience, deceived by the glamor

of brilliant statistics and ambitious of fame as operators, will decide upon and perform these operations when there is no necessity for them, and no benefit follows them, or they are fatal?" That such complaints are well grounded cannot be denied; but this admission by no means implies that the operation is to be condemned. Through all history great advances in every sphere of life have had unworthy advocates, but whose existence only serves to establish the value of the cause they champion. And in our own profession have not vaccination and *anæsthesia* and ovariectomy been subject to such animadversion and misinterpretation, and yet have vindicated their claim to the position of benefactions to the race? So shall it be with laparotomy, and surely it is well within the province of this Association to more clearly establish the propriety of the operation, remove unreasonable objections, and seek to prevent its undue performance.

An opinion has large credence among the laity, and is endorsed by some members of our profession that intentional abortion is a common crime, and statisticians and social scientists see in the decreasing fecundity of American women clear evidence of the truth of this charge. That some women are guilty admits of no doubt; but that it is so universal an evil as sensational literature, especially of non-professional origin, would indicate, I do not believe.

Permit me to direct your attention to a more demonstrable cause for diminishing fertility. I need but remind you of the deleterious influence of social habits and circumstances over the functions and physique of women, and consequently how many fashionably educated girls are incapable of completing the process of maternity, or if they do pass through it how seriously they are damaged thereby. Those who are fond of charging American women with the crime referred to cite us to the rich, the educated, the refined as guilty, while their sisters who are less favored financially, and humbler socially bear their due proportion of children. Now is it not a truthful statement, that the first class are the physically feeble, the enervated, and *therefore* incapable of carrying the process of reproduction to its ultimate

perfection? To corroborate this view, Dr. W. W. Johnson has recently said that "the confirmed ill health so common after the establishment of the marriage relation and childbirth among American women in a large number of cases is dependent upon alterations and diseases of the genitalia," which probably are the more intense because of the original debility of the subject, and Dr. J. C. Hoag says: "that a lack of fecundity on the part of a woman is often due to endometritis, and is overcome by the cure of the diseased condition is a matter of frequent clinical experience," and Kleinwaechter has shown that of ninety cases of sterility after the birth of one child nearly one-half were subject to inflammatory processes of the genitalia. Accept these statements as true and a rational explanation of the asserted evil is found, and it is at once transferred from the domain of ethics and morals to within the pale of our professional care and becomes a fit subject for our efforts at cure; and at the same time, vindicates those whom we look upon as the purest and best from the indiscriminate charge of murder of their unborn children.

I believe the influence of the genitalia over the general system especially in its nervous manifestations has been exaggerated. The idea expressed in classic language that "Woman is because of the uterus," or more correctly "because of the ovaries," though in some respects true has led to false deductions and erroneous practices.

J. Matthews Duncan has recently said: "The influence of disease of the ovaries is not so potent or important as that of the liver on the health of the individual," and the careful study of Dr. Grace Peckham is strong testimony against the disproportionate influence of morbid conditions of the organs of generation. Uherek thinks that entirely too much attention has been paid to the genital organs in connection with neuroses. Even if there are lesions which have resulted from parturition the general condition should receive a large share of attention, and observation of results of operation for nervous diseases confirm these views. Our associate Wathen has recently said: "The removal of healthy ovaries or tubes to

cure epilepsy or vague nervous diseases not due to irritation of the pelvic organs was not more consistent than the castration of a man for similar purposes," and our associate Vander Veer's experience regarding hystero-epilepsy was that it had not been cured by removal of the appendages, and Parvin, quoting Reverdin, says that among all the cases of castration for nervous diseases in Paris very many have not resulted favorably. Now with such testimony is it not incumbent on us at least to utter an admonition against the removal of normal ovaries for lesions of the nervous system?

A subject of practical importance urgently demanding attention from the obstetrical section of our association, is the constantly increasing inability of woman who should be "nursing mothers" to furnish milk for their infants. No words from me are needed to impress upon you the fact that many women who have borne children are incapable of nourishing them, but perhaps you have not appreciated the fact of the very large proportion who are thus defective, probably about 40 per cent. with us; and according to the investigations of Escherich and others 59 per cent. of mothers become incapable from physical causes of nursing their children within two months after delivery. The incapacity to perform this function, upon which more than any other the well-being of the child depends, is in large degree the inherited result of habits tending to impair the integrity of the mammary gland, as vicious modes of dress, disregard of maternal duty, and even sometimes suppression of the developing gland; all of them conditions over which we may hope by degrees to exercise salutary influences and bring about a better state of affairs.

Another topic well worthy of our most careful thought is, what can be done to mitigate the pains of labor? We all have promptly adopted the custom of lessening the intensity of suffering in the latter part of the second stage by the use of anesthetics, and almost as common is the use of chloral at an early period; but my impression is that with the great majority of obstetricians but little is done to lessen

pain during a large part of the process of delivery.

With the abundant therapeutic resources of the present day, we ought surely to divest this ordeal of the intensity of its pain.

I trust by another meeting to make report upon experiments I am now making.

Our highest conception of a benefactor is one who prevents evil, rather than one who mitigates or seeks to cure the evil after its development. While the duties of the physician are to a very great degree limited to the removal of existing diseases, and in such office he must gain his most *obvious* triumphs, yet all will concur with me that our whole duty will not be done unless we seek to *prevent* many of the ills we so often are called upon to cure. And herewith I feel that I offer you one of the most difficult problems to solve. In adopting a new remedy or advocating a new procedure in surgery we address men whose training qualifies them to judge carefully and appreciate the means and the end in view, but to advocate hygienic or preventive measures, we appeal at once to the laity and invoke the co-operation of those little disposed to make the effort demanded.

But this indifference is neither the sole reason nor the most potent cause for the imperfect results accruing from labor in this direction. History plainly teaches us that physical degeneracy has been an invariable sequence of national success and financial prosperity. I need only remind you of the fact, that the most learned and prosperous nation in each age of the world has succumbed to a less civilized race. To borrow from a recent writer, "It is the old, old story of riches, luxury and effeminacy, and a horde of athletic savages. Once let the conventionalities and artificial restrictions of a so-called civilization interfere with the healthful simplicity of nature and decay is certain."

Must we not admit the essential truth of this statement? How fragile are many of the women with whom we have to deal! Time forbids that I should go into details, but you are well aware that the methods of culture, physical, intellectual and social, to which a girl

is subjected, not only do not conduce to physical vigor, but lead to positive deterioration and serve to magnify defects of constitution which may have been derived from ancestry, and as the struggle for bread winning grows sharper the girls of the humbler classes are subjected to hardships which impair their powers and retard healthful development. It has been clearly shown that the anaemia of puberty is much more common among girls who pursue sedentary occupations, and in cities than in the country. Recognizing the existence of these influences inimical to the health of women, it becomes especially a duty of men in our section of the profession to strive to effect their removal.

While presenting these topics to you as worthy the consideration of an assemblage so competent to investigate all that pertains to the science and practice of obstetrics and gynecology, I have been much impressed with the value of a carefully prepared system of collective investigation by which the experience of so large a number of active workers might be collected and contribute largely to the decision of mooted points of practice.

The beneficent result of comparative study of a given topic is remarkably demonstrated in the modifications of Lister's methods of disinfection. With what alacrity did nearly all operators adopt his suggestions, and how speedily did they learn that much of his method was superfluous, and how little now remains of the original system, and yet we will all bear glad testimony to the soundness of his principle and to the glorious fruit it has borne. So, too, the Cæsarean section, upon which have been grafted so many modifications, nearly all of which have been submitted to the criticism of practical experience, and have been cast aside as harmful, or at least needless. With such examples no further argument is required to establish the value of a carefully devised system of case taking and reporting under our supervision.

But one thought more, and I have done. Grand as *has* been the success of our profession, we are not to rest here. We can appeal to our past experience and realize the instability of

much that may have cost us great toil. Slightly to change a remark of Dr. Alexander Simpson, "Doctrines and practices in favor at this Congress are sure to be modified and may be even superseded at the next; the lapse of five years takes the bloom off of the best text-books, and in ten years they are discarded, or have to be well nigh re-written." Science knows no sentiment, and we can cherish the achievements of the past only so far as they aid us for the future; and what is our future? Dr. E. M. Moore recently said: "It is difficult at the present moment to define the possibilities of modern surgery. It is a fit representative of the time we live in—a combination of science and action," accepting that as expressive of our present status. I shall add, and as in other departments of applied science almost every day brings a new surprise, so we may confidently anticipate advances and successes which shall as far surpass our present attainments as these do those of the past generation; and happy may we count ourselves that this Association, so auspiciously established, shall contribute to these magnificent and beneficent attainments.

## ORIGINAL ARTICLES.

### LAPAROTOMY IN PERITONITIS.

Read before the American Association of Obstetricians and Gynecologists, at Washington, Sept. 18th, 1888, by E. E. MONTGOMERY, M.D., Prof. of Gynecology in the Medico-Chirurgical College of Philadelphia, and Obstetrician to the Philadelphia Hospital.

**T**HE dread of disturbing the peritoneal cavity has been so great as to well justify the assertion of Wagner, that he and his contemporaries had been nurtured in the fear of the Lord and of the peritoneum.

Inflammatory and suppurative processes, that in other portions of the body would have received early surgical intervention, were here allowed to continue their course undisturbed, until the vital forces of the patient were exhausted, or Nature had fortunately furnished a channel of exit. This seems the more remarkable, when we consider

the work that had already been done in the field of abdominal surgery.

Peritonitis varies in its phenomena according to the condition producing it. The existence of idiopathic peritonitis was formerly denied; but it has been demonstrated that the disease can arise from exposure to cold and dampness. In this form, the quantity of exudation is limited, unless the inflammation is very acute, and is likely to be of a serious or a fibro-serous character. As the inflammation subsides, the exudation is absorbed, and after recovery the patient seems none the worse for the attack.

Such a fortunate result, however, is the exception rather than the rule. The exudation, more frequently, becomes purulent, or there is an early secretion of pus.

Pus collections occur in the abdominal cavity, either as an exudation or as encysted collections, and may result from either acute (partial or diffuse) or chronic peritonitis.

The collections of pus in the circumscribed form are generally of slight extent, and are, most frequently, found in the region of the vermiform appendix and female sexual organs. In chronic peritonitis, the quantity of fluid exudation is not usually very considerable, and but rarely of a purely purulent character. The largest and most extensive collections of pus take place in acute peritoneal inflammations, and are frequently the product and residuum of such disease. The purulent exudation is more likely to occur in the puerperal and metastatic forms, in which it is introduced through contact of the peritoneum with heterogeneous bodies and fluids, and ulcerative processes in the various abdominal organs.

According to Bamberger, the exudation, in its beginning, is fibrinous, but that there is a primary pus formation is evident from the fact that Abercrombie and others have found pus in the abdomen, where death had occurred within 48 hours of the beginning of the inflammatory process. Kaiser, in a case of puerperal peritonitis of 36 hours duration, found over a gallon of pus. As it is now recognized that the maxim "*ubi pus, ibi evacua*" should govern as well in the peritoneal as in the pleural

cavity, the question of how we shall determine the presence and character of an exudation is an important one.

Kaiser says that from the early part of the present century, the following complex symptoms were considered as indicating empyema of the peritoneum: If the patient continued eight or ten days sick without any alleviation, we had every reason to fear this sad termination. If up to this time he has had severe chills, cold extremities, and the abdomen becomes less painful, but is swollen, heavy and doughy, evening chills, pulse continues same or is smaller (a symptom that Abercrombie regarded as very ominous), frequent, free, and offensive fecal discharges, and the various excretions and secretions remain disordered, it is probable that pus is either forming or has formed. An important indication of its presence is hectic fever.

Martin concedes the purulent character of the exudation, if at the end of the acute stage of the peritonitis:

1. Fluctuation is distinct;
2. The quantity of fluid remains stationary, or slightly abates;
3. The limits of the dull percussion sound are increased in the upright position; and
4. Alteration of the level of dulness takes place according to position. Attacks of chills, cessation of spontaneous pain, continuation of sensitiveness upon contact and movement, make the diagnosis certain. The fourth rule can not be insisted upon as absolute; for the pus may, indeed is likely to become encysted, and its level does not change with the body movements.

The diagnosis of suspected pus in the peritoneal cavity can be confirmed by exploratory puncture, which may be done by the use of the hypodermic or small aspirator needle.

Small quantities of pus, or large collections, enclosed between the folds of the intestines and mesentery, are difficult to recognize. By palpation, percussion, and exploratory puncture, we are able to recognize only collections sufficiently large to produce dulness upon percussion, afford the sensation of fluctuation, or such as are palpable as swellings. The most readily recognized

are collections in the anterior abdominal wall, and in the pouch of Douglas. A free effusion in the latter is mostly felt as a trifling sense of resistance, which, Hegar says, at best, is similar to the resistance of a feather pillow. The posterior vaginal fornix, however, is perceptibly broadened. Pus may form in the subserous tissue of the anterior wall (peritonitis externa) to be differentiated from an intraperitoneal collection. Frequently both forms may combine and render the diagnosis still more difficult. It should be remembered that an extraperitoneal abscess may penetrate inwards and produce an attack of peritonitis.

Cases of peritoneal empyema may terminate in several ways: 1. Absorption of the serum may occur and even pus corpuscles may be taken up by the lymphatics, but mostly after they have undergone fatty metamorphosis.

2. Inspissation, cheesy metamorphosis, and cretification of the pus through absorption of the serum, disintegration and cretification of the detritus. This deposit remains a source of danger, as by its absorption it may lead to the development of pyæmia and tuberculous processes.

3. Decomposition of the pus and the formation of gases, which always result fatally unless an early evacuation of the poisonous elements is secured.

It should be remembered that while pain is the most frequent symptom of peritonitis, cases occur in which the onset of the disease is very insidious, and pain is entirely absent.

A case of puerperal peritonitis occurred in the writer's experience in which, in addition to absence of spontaneous pain, the distended abdomen was not sensitive to pressure, and could be kneaded over without the patient showing any trace of suffering; she died within thirty-six hours and the autopsy disclosed over a quart of pus within the peritoneal cavity.

The progress of purulent peritonitis is extremely rapid, and its fatality is well known. The cause of death is the rapid absorption from a large serous surface.

It is not the purpose of this paper to discuss the medical treatment of this disorder.

Non-purulent effusion may be evacuated by puncture; but suppuration in the peritoneal cavity should be treated like suppuration in the pleural and articular cavities, and the result will correspond to the promptness and thoroughness of the treatment. No procedure short of laparotomy is justifiable; for it allows of thorough evacuation of the pus, complete cleansing of the abdominal cavity, separation of the adhesions (which may form collections of pus), the removal of exudation and perfect drainage. It also permits thorough examination of the abdominal cavity, and may enable us to discover and remove the cause of the inflammation.

Barwell, in a case of suppurative peritonitis, contented himself with washing and sponging out the abdomen thoroughly, and closing the wound without drainage. He objects to the insertion of the drainage tube from above, as being an ineffective method of emptying the cavity. Treves, Truc, and others favor the drainage tube, practicing frequent irrigation where the conditions require it.

In the puerperal form suppuration is a prominent and early result. In the hyper-acute, the progress is exceedingly rapid, terminating in death in two or three days. The surgical treatment is exceedingly important, and is especially indicated by marked tympanites and peritoneal effusion. The tympanites may be relieved by intestinal puncture, as was first practiced by Depaul.

If the effusion is simple serum, it too may be evacuated by puncture; but where sanious or purulent, laparotomy and drainage should be practiced.

*Perforative peritonitis* causes a great diversity of opinion as to the limitations of the operative procedure in its traumatic and pathological forms. Escher and Truc would limit the performance of laparotomy to the cases of traumatic origin; for in these the adhesive inflammation cannot be relied upon to limit the escape of the contents of the viscus. The patient is usually healthy, and the tissues of the viscus are in good condition, and sutures are readily borne should resection be required. In pathological conditions, the

adhesive peritonitis can render more valuable service; the intestines may be extensively diseased; the condition of the patient is usually exhausted by the duration and character of the disease, so that the strength is not fitted to endure a protracted operation, and the softened state of the tissues gives no guarantee of continued closure. Hence they would not operate in perforations resulting from typhoid, dysenteric and tuberculous ulcers. Mikulicz, however, advises the operation in every case of perforative peritonitis, where the patient is not already in collapse, and directs that the operation should be done as soon as possible. A number of successful cases seem to demonstrate the wisdom of such advice.

Ebstein lays stress upon the abdomen being hard and rigid as an indication of impending perforative peritonitis.

After perforation, we are likely to find the abdomen distended from the escape into and the formation of gases in the peritoneal cavity. The distinction between intestinal and peritoneal meteorism as they occur in acute and perforative peritonitis, Wagner says, is that in the former, coils of intestines are visible, and movements may be felt, or, at least, heard by auscultation, while in the latter no movements are perceptible by any method, for the intestines are pushed back by the gas in the peritoneal cavity. The treatment, as has already been indicated, is to open the abdomen, search for and suture the perforation, cleanse the cavity, and use drainage if necessary.

*Peritonitis* resulting from the rupture of abscesses demands prompt laparotomy, and the success of Tait, Treves, Israel and Burchard show that this operation, with careful cleansing of the abdomen, can save the patient.

In no class of cases, probably, is the abdominal surgeon more tried than in inflammations of the cæcal region. Cases of inflammation occur and are medically treated, while the surgeon anxiously watches the case until the severe symptoms subside and convalescence takes place, and then rejoices that he did not yield to the temptation to operate. Another case will have an attack apparently no more intense, will for a time progress well, and then will

undergo a sudden augmentation of the inflammatory action, and the patient rapidly succumbs. It is a constant regret that this patient had not been subjected to operation. Some years ago, I was called to treat a young man aged 19 years, who complained of severe pains in the right inguinal region following diarrhoea. Upon examination this region was found exquisitely tender to pressure; a tympanitic swelling extended upward and toward the median line. He was promptly placed in bed, leeches, brought under the influence of morphia, and kept upon a liquid diet. The whole abdomen became tympanitic and tender, though the right side remained the most sensitive. The temperature did not exceed 102°. By the eighth day all the inflammatory symptoms had begun to subside, and the pain had ceased. Early on the ninth day I was called and found that he had been awakened from a sound sleep by a tearing pain; he was then in collapse, and died a few hours later. The autopsy disclosed that the end of the appendix had sloughed off; cæcum and appendix were enveloped in a collection of pus enclosed by the matting together of intestinal loops; the intraperitoneal abscess sac had, however, been ruptured by a hemorrhage from the vessels of the appendix. The enclosure contained nearly a quart of blood, a portion of which, with the pus, had escaped into the abdominal cavity.

How are we to distinguish the cases for operation, and when it should be done?

In those cases in which it is evident, from the absence of severe pain and tenderness, tympanites but slight, and an accumulation of a semi-solid consistency, that faecal impaction or catarrhal inflammation exists, we may wait. In cases, however, where the onset is sudden, pain intense, spread of peritonitis rapid, early treatment is important. Of 176 cases quoted by Fitz, thirty-four per cent. died in the first three days. In children the mortality reached seventy per cent. The majority of these cases result from perforation of the intraperitoneal appendix. From this lesion abscesses form, allowing extravasation of faeces, gas and other infectious materials arising from necrotic pro-

cesses, into the peritoneal cavity; or the intestines may be glued together, and shut off the infectious materials from the rest of the cavity, forming an intraperitoneal abscess; or, again, through old adhesions the posterior peritoneum may be involved and form an extraperitoneal abscess.

We have seen, from the rapid progress of the disease, the importance of early interference. Sands, in a successful case, operated upon the second day.

Operators differ as to the proper method of procedure. Sands makes the incision perpendicular to the middle of Poupart's ligament, while Willard made it parallel to the ligament. Either incision would be preferable to the median in affording more convenient access to the affected structures. If the appendix is found gangrenous, or the seat of the perforation, its amputation and suturing of the stump would seem preferable to ligaturing the appendix, as has been done in some cases. After the removal of necrotic tissue and closure of the perforations, the peritoneal cavity should be thoroughly cleansed, a drainage tube inserted and the wound sutured and dressed.

The importance of at once giving free vent of septic or purulent collections in peritonitis following surgical operations upon the abdomen is now so well recognized a principle of treatment that it does not require discussion.

In no class of diseases, probably, is the beneficial influence of abdominal section better displayed than in the treatment of tubercular peritonitis. This plan of treatment is purely empirical, and its beneficial effects were determined by accident. For a knowledge of its value we are indebted to Spencer Wells, who operated upon a case of supposed ovarian cyst, which proved to be one of tubercular peritonitis, in which the cavity was studded with tubercular masses, and omentum and intestines were matted together. This patient was in good health twenty-three years later.

A number of cases have occurred, in which laparotomy has been done under mistaken diagnosis, in tubercular disease, with almost universally favorable results. In this connection, a case of

my own, I trust, will not prove uninteresting. A young girl, aged 16 years, was seen in consultation with Drs. Heilman and Stone. She had been suffering for four days with frequent attacks of vomiting, which later had become stercoraceous; the abdomen was very tympanitic, and quite tender to pressure. No faecal evacuation had occurred since her sickness, and the secretion of urine was scant. The highest temperature had been  $101^{\circ}$ , pulse 120. General appearance was bad. She had been a very slight, poorly nourished girl before this attack. She was supposed to be suffering from intestinal obstruction, and laparotomy was determined upon with a view to ascertain, and, if possible, remove the cause. A median incision, about five inches long, was made; and a few ounces of dirty serum removed. The intestines were drawn out and examined, but no obstruction was found. The peritoneum was studded with millet seed sized tubercles. A number of punctures were made in the intestines with a hypodermic needle to evacuate the flatus, and enable us to close the wound; the cavity, owing to the bad condition of the patient, was hastily washed out, and the abdomen closed. Two days later the bowels were freely moved, and the subsequent progress of the patient was unusually rapid. Her condition of health and general appearance since have been very greatly improved.

Of thirty cases collected by Kummell, and six by others, but six ended fatally. In a number, various antiseptics, as iodoform, carbolic acid, and corrosive sublimate, were used; but the relief seems just as certain and permanent where the operator has contented himself with merely washing or sponging out the cavity with pure water. The favorable result is attributed to the removal of the serum, which serves as an excellent culture fluid for the multiplication of the bacilli. The unexpected relief obtained in such cases by laparotomy might lead to the correctness of the diagnosis being questioned; but the cases of Poter, Hartwig, and others, in which portions of the tissue were removed and found to contain the characteristic bacilli of tubercle, and in which the results were

equally favorable and permanent, leave no doubt as to the correctness of the diagnosis.

Schwartz gives the following indications for the operation:

1. Insecurely fixed diagnosis of peritoneal tuberculosis, wherein incision should be preferred to the customary puncture.

2. Where the operation is performed, remove the transudation completely, preferably in the dry way with disinfection of the peritoneum, and exact closure of the wound.

3. Youthful age should, according to surgical experience in other forms of disease, afford no contra-indication to the performance of the operation.

4. A moderate affection of the lungs should be no contra-indication to the operation; but an additional indication for it, as through the removal of the transudation, the respiration is improved, as well as the strength and general health.

Incision has this advantage over puncture as a method of treatment in that, after the former, ascites does not return, while it is the rule for it to rapidly accumulate, following the latter.

In conclusion, we cannot do better than quote the following from Truc: "The opening of the abdomen has lost much of its gravity, and we believe that we have demonstrated that certain forms of peritonitis can be cured by opportune and methodical surgical treatment; that is enough to condemn systematic refusal to operate. Instead of being a contra-indication, it (peritonitis) should become a positive indication. Death, in the cases of which we speak, is certain; we have seen that the operation may save the patient. Why hesitate to give the latter some chance of recovery?"

### THE MILITARY RED CROSS CORPS.

BY W. THORNTON PARKER, M.D.  
(Munich),

Late A. A. Surgeon, U. S. Army; Medical Examiner, 3d District, R. I.; Member of the St. John's Ambulance Association, England, etc., etc.

(Concluded.)

One of the best appliances for ready use in first aid to the injured is the

Esmarch triangular bandage. This is a strip of cloth fifty inches long, triangular in shape, its greatest width being 24 inches. Upon the bandage are six pictures illustrating its use, and with the bandage is a little book describing its use.

These bandages can be obtained of the American Society for Instruction in First Aid to the Injured, New York City.

TRANSLATION.

FIRST AID TO THE INJURED.

Under this title the undersigned Society offers to persons in every state and condition—in the work-shops, manufactories, mines, and railroad organizations, engineering undertakings, to all travelers and emigrants, and to any thoughtful family—an emergency packet for wound-dressing, which, thanks to its small, compact form, its convenient arrangement and facility of packing, will give it a place everywhere; it can be carried under all circumstances. Each one of these packets is sold for one franc (fifty centimes) postpaid; and contains: First, a compress composed of cotton-charpie of Dr. Burns, and an antiseptic bandage. These two kinds of bandage have the property of absorbing the fluids, blood and pus, and protect the wound against hurtful influences. 2. Two bands of linen, one wide, the other straight, with pins for fastening them. 3. Some "ping-hawaryambi," as a hæmostatic application. 4. A triangular piece of linen prescribed by Dr. von Esmarch. With the aid of this apparatus the majority of bandaging operations may be accomplished without any special skill. The method is as follows: The compress, which is folded in four, unfolds in such a manner that the cotton lint will be covered entirely by the bandage (antiseptic), which gives a surface similar in form to a sheet of letter-paper. We cut off each time the requisite quantity for covering the wound. After having washed the latter, and controlled the hæmorrhage by means of the application of the ping-hawaryambi, it is covered with a piece of the compress, which is fastened by means of the linen bandages, which, should the wound be upon the head, neck, trunk, or main parts of the extremities, is done by the use of the

triangular bandage (Esmarch's). If it be a case of an open or deep wound, you form with the compress a pad proportioned to the size of the wound, which is introduced therein after previously saturating it with good olive oil, if this be within reach. According to the abundance of the secretions from the wound, it will be necessary to change the bandage once or oftener during the day; in this case, the same bandage and the same linen can be employed; but it is important to renew the compress or the pad. As to the employment of the Esmarch's bandage, we will quote the words of Professor Esmarch, who, in his celebrated work entitled "The First Aid in Bandaging on the Field of Battle," expresses himself as follows:

"According to the part of the body wounded, the triangular bandage is used as follows: It is folded in the form of a cravat by rolling the point several times in the direction of the lower edge; the oftener it is folded the narrower the bandage becomes. Under this form a practical bandage is made, not only for wounds upon the neck, but also for those on many other portions of the body; for example, the eye, the forehead, the ears, the cheeks, the chin, and the lower jaw. It is employed in the same manner for the simple muscular wounds of the extremities, and for fixing the splints and other protective apparatus in the case of fractured bones; besides making all of it as a sling for supporting the wounded arm. The manner of employing the bandage under this form is so simple that no particular description is necessary. The ends are well fastened by means of strong pins, or well knotted one with another. For dressing a wound on the head, or a simple scalp wound, the bandage is placed upon the head in such a manner that the lower border will be brought directly across the forehead, the point hanging towards the neck. Then the two ends are passed backwards, behind the ears, turned again and tied in front. The point hanging in front is pulled down firmly, returned upon the head, and fastened on the top of the head with a pin (head bandage or cap).

"To bandage a wounded hand a small bandage is necessary. The hand is placed upon the opened bandage in

such a manner that the wrist covers the middle of the lower edge, and the points of the fingers are directed to the pointed end of the bandage. The point is then turned backward over the hand in the direction of the forearm. The two remaining ends are crossed over the point of the bandage and tied on the other side of the wrist.

"For the foot the sole is placed on the middle of the bandage, so that the toes are directed towards the point. The point is then brought forward over the top of the foot and the two ends are passed around the malleolar processes, crossed on top of the foot and tied under the sole.

"We can also bandage the stump after amputation in the same manner. The superior border or biased edge is placed around the limb above the extremity of the stump, turned around the wound, the hanging point is brought up over the wound, and the two free ends are adjusted over these and tied.

"To comfortably sling or suspend a wounded arm the ends must be placed over the uninjured shoulder, and upon the neck sufficiently in front so that it will readily pass around the neck to the other side, and it is there fastened, while the other end hangs in front of the body. We carefully place the bended arm upon the middle of the linen, advancing the point below the elbow several inches. Then the end which hangs before the arm is brought back to the side of the shoulder of the wounded arm and tied with the other end upon the back. Then the point is brought around the elbow and fastened with a pin. This bandage is called the large scarf or big sling bandage.

"For bandaging wounds upon the chest, the middle of the linen is placed upon the chest, the point raised and turned backward, passing over one shoulder, and the inferior border adjusted (at the waist) in the region where the chest and abdomen unite; then bringing the two ends backward and tying them together upon the back. The pointed end passed over the shoulder is then drawn down and made to pass under the knotted end, and adjusted by means of a pin or knot. For wounds on the back one proceeds in the same manner, but inversely. For

wounds upon the shoulder, the bandage is cut into two equal parts, of which one is folded in cravat form, and is used as a little scarf for the forearm, whilst the other is placed upon the wounded shoulder in such a manner that the point shall be upon the side of the neck and the superior border upon the middle of the forearm. The ends are then passed around the under side of the arm, crossed beneath the point of the elbow, and tied together on the exterior surface of the forearm. The point of the bandage is then slipped under the scarf at the neck, plaited back upon itself, and fastened with a pin at the top of the shoulder.

"In the same manner the bandage is placed upon the hip; and here we often need the entire bandage, because the upper part of the thigh is much larger than that of the arm. The inferior border of the bandage is passed around the largest part of the thigh, and the ends fastened with a double knot, but in the cases where the thigh is too large it is pinned. The point of the bandage is adjusted in the same manner as for the shoulder, by passing under the leather belt of the soldier, returned upon themselves and fastened with a pin. When there is no leather belt it will be necessary to use a second bandage folded in cravat form."

#### THE DRILL.

Stretchers, in the proportion of one for every three men of the Red Cross Corps, will be laid out on the parade ground, in a row, at suitable intervals, and in such a manner as to allow the corps to be drawn up about a dozen paces in the rear of them. The heads of the stretchers towards the company line.

The company will fall in, in single rank, with side arms only, under the supervision of the Red Cross Sergeant.

Corps, attention.

Count threes.

Count sections. At this command, No. 1 on the right of the line counts "one," the second No. 1, or the fourth man, "two," the third No. 1 counts "three," and so on.

*Stand to stretchers. Quick, march.* At the command the sections oblique right and left, and march in the direction of their stretchers; section "one"

to the stretcher on the right; section "two" to the next, and so on.

Upon arriving at the stretchers, No. 1 takes station at the head, No. 3 at the foot, and No. 2 on the right centre.

*Prepare Stretchers.*—No. 3 faces about; No. 2 left face at the command *prepare*. At the word *stretchers*, all kneel on the left knee, and proceed to unbuckle the straps, separate the poles, hook in the "transverses," and stretch the canvas to the full extent. The free end of the pillow is next secured by No. 1. The slings on the handles of the poles are next secured. When this is completed, stations are taken as at first command, stand to stretchers.

*"Fold-up" Stretchers.*—No. 3 faces about; No. 2 left face. At the command stretchers, all kneel on the left knee and proceed to take off the slings, unfasten the "transverses," and buckle the straps. This completed, all rise and resume the original position. •

#### TO LIFT AND LOWER STRETCHERS.

Unity of action and steadiness of motion are the essential points to be remembered in stretcher drill, and especially in lifting the wounded.

Nos. 1 and 3 must accustom themselves to harmony in their work, acting simultaneously and steadily; No. 3 waiting for No. 1, should the latter not be quite ready to lift or lower. No. 1, when ready, will call out, "go on," or if delayed, "stand fast."

*Lift Stretchers.*—Nos. 1 and 3 stoop down; each man grasps a double sling at its centre with the fingers and thumb of the right hand, removes it from the handle, and places the sling over their shoulders, dividing it equally. Then slip the loops of the slings over the ends of the poles, commencing with the left, and then firmly grasp the poles. No. 1 says "ready," and No. 2 replies "go on," or "stand fast," as the case may be. When both are ready, Nos. 1 and 3 steadily raise the stretcher off the ground and stand up, holding the stretcher at the full extent of the arms. No. 3 must closely conform to the movements of No. 1, so that the horizontal position of the stretcher may be maintained throughout. Directly No. 2 perceives that Nos. 1 and 3 have risen, he proceeds at once to adjust the slings on the neck and shoulders of

No. 1, and afterwards on No. 3. As soon as he has attended to this, he will take his post on the right centre of the stretcher.

*Lower Stretchers.*—On the caution lower, Nos. 1 and 3 will be prepared to stoop; and at the word stretchers, both men lower the stretcher very cautiously to the ground. No. 3 again closely conforming to the movements of No. 1. They then each proceed to slip the loops of the slings off the ends of the poles, standing up remove the slings from their shoulders, double replace them again on the handles, and then resume the position of attention as in the command stand by stretchers.

#### MARCHING WITH STRETCHERS.

The mode of progression of the bearers should be so regulated as to avoid any impulses being thereby communicated to the patient in the stretcher. This can best be accomplished by the *broken step*. Both bearers should take special care to march with an even step and not to lose time at the command *advance*. No. 1 steps off with the right foot and No. 3 with the left. The pace should be quick time and not to exceed twenty inches in length, the feet should be kept close to the ground and the knees slightly bent, the motion should be a gliding step and not a springy walk. Each section should be so far as possible sized, men comprising it should be as nearly as possible of the same size and physique.

The stretcher *must* be maintained in the horizontal position on all occasions, and in a position as near the horizontal as possible—the inclination *downwards* in the latter case being towards the feet of the patient. On this account, where there is any difference in the height of the bearers, No. 1 should always be the taller man. Every effort should be constantly kept in mind to insure the greatest amount of safety to the patient who is being carried.

At the command stretchers *retire*, each detachment will wheel to the right about and continue the march.

#### LOADING AND UNLOADING STRETCHERS.

Stretchers advance.

Take post at wounded.

Lower stretchers.

Lift wounded.

Nos. 1 and 3 remove the slings, and take position at the head and feet of the wounded, No. 2. at the hips. The stretcher, whenever it is practicable, should be left on the ground one pace to the rear, and in line with the patient's body. At the command, ready, from No. 1, all gently and firmly lift the patient, carrying him back and over the stretcher. Each man has to raise and lower a certain part of the weight of the patient's body; but all must act in concert, or else his injuries and sufferings may be seriously aggravated by want of attention to this all important point. The medical officer cadet of Red Cross Sergeant on duty immediately in the line of fire, or in the vicinity of the wounded now examines the patient, renders first aid—attaches descriptive card with name and rank, if possible—and orders *lift stretchers*. This command is executed as already explained.

In lifting the wounded, whether to place them on stretchers, or to carry by hand from the field, No. 1 passes his arms directly under the arms of the patient, and clasps his own hands and fingers in front of the wounded man's chest. This affords a strong grip, and does not generally add to the distress of the patient, or No. 1 can pass one hand round by the opposite axilla under the patient's neck, and the other under the shoulder nearest to him, and he is to avoid disturbing a broken arm. No. 2 passes his hand and arms under the patient's loins and hips, and No. 3 passes both arms under the lower limbs, if there should happen to be a fracture, with one hand above and one below the seat of fracture in order to support it, and to prevent movement of the ends of the broken bone. As it facilitates the lifting the patient, if he possibly can he is now to be directed to clasp his arms round the neck of No. 1. bearer.

No. 1 now commands "Advance," and all step off as directed in the marching of detachments with stretchers. Where severe wounds have been received involving fractures of one or more bones, "first aid" must be rendered before patient is moved to the stretcher.

#### GENERAL RULES FOR THE PROPER CARRIAGE OF "STRETCHERS"

1. When braces or shoulder straps

are used to assist the bearers in carrying stretchers, care should be taken at starting that they are buckled so that the parts supporting the poles are all at equal distances from the surface of the ground.

2. As most ground over which wounded have to be carried is likely to present irregularities of surface, it becomes an important matter for bearers to practise the carriage of stretchers, so as to acquire a facility of keeping the stretcher level, notwithstanding the ground is uneven. Bearers trained and habituated to this duty perform it with ease and dexterity, irrespective of differences in their own respective heights; while those who have not practised it are not unlikely to cause considerable distress to the person carried, when they have to carry him up and down hill, in consequence of their deficient training. A concerted action of the front and rear bearers is necessary, and each must be aware what part he is to perform according as the end of the stretcher at which he is placed is rendered higher or lower by the unevenness of the surface over which they are passing. These rules are copied from Surgeon Longmore's Treatise on Ambulances, p. 173, *et seq.*

The act can readily be acquired by practising the carriage of the stretcher up and down steps. In this practice the front and rear bearers should occasionally change their respective positions. A bearer should also be carried on the stretcher in turn, so as to be made practically aware of the effects of even and uneven carriage.

3. If the ground over which the conveyance has to pass presents a general ascent, and the bearers are of different height, then the rear or No. 3 bearer should be the taller and stronger man, for his greater height and the greater strength of his arm will be useful in supporting and raising the stretcher up to the level of the end carried by the foremost man. The weight of the stretcher will naturally be thrown in the direction of the man on the lower level.

4. If the ground presents a general descent, the front or No. 1 bearer should be taller and stronger for the same reason as those just given as regards No.

3 bearer under the opposite circumstances mentioned on Rule 2.

5. A sick or wounded person on a stretcher should be carried, if the ground be tolerably level, with his face looking towards the direction in which the bearers walk. The front of No. 1 bearer then supports the end of the stretcher at which the patient's feet are placed; the bearer near the patient's head is the rear bearer.

6. If the bearers have to carry the stretcher down hill, the rear or No. 3 bearer should support the end on which the patient's head is placed. The reverse position should be assumed by the bearers both as regards going up hill and going down hill, in case the patient being carried is suffering from a recent fracture of the thigh or leg.

7. The patient's comfort and welfare will be best consulted as a general principle by the arrangements named in Rule 6 and 7. Although under all circumstances the level position should be sought for as much as possible, still if the slope of the ground be such that it cannot be attained, it appears desirable that the inclination downwards should be towards the feet rather than towards the head of the patient. But with regard to the exception named, the reverse position of the patient is directed, in order to prevent the weight of his body pushing the upper end of the broken bone down upon the helpless and motionless portion of the limb below the seat of fracture.

8. No attempt must be made to carry a helpless patient over a high fence or wall if it can possibly be avoided; it is always a dangerous proceeding. The danger is of course increased in proportion to the height of the wall or fence. But even if the wall be not much higher than one over which the bearers can step, the stretcher must be made to rest upon it, to the inconvenience and probable pain of the patient, while each bearer in succession gets over the obstruction; and it is better to avoid even this inconvenience, provided the avoidance does not entail great delay. If the fence or wall be high, either a portion of the wall should be thrown down, or a breach made in the fence, so that the patient may be carried through on the

stretcher; or, if this be not readily practicable, the patient should be carried to a place where a gate or opening does already exist, notwithstanding the distance to be traversed may be increased by the proceeding. It is better that the transportation should be somewhat delayed than the safety of the patient's limbs or life risked.

9. In crossing a ditch, dyke, or hollow, the stretcher should be first laid on the ground near its edge—Nos. 1 and 2 then descend. The stretcher with the patient upon it is afterwards advanced, Nos. 1 and 2 in the ditch supporting the front end of the stretcher, while the other end rests on the edge of the ground above. While thus supported, Nos. 3 and 4 descend. All the numbers now carry the stretcher to the opposite side; and the forepart now being made to rest on the edge of the ground, while the rear part is supported by Nos. 3 and 4 in the ditch, the Nos. 1 and 2 are left free to climb up. The stretcher is now pushed or lifted forward on the ground above, and rests there while Nos. 3 and 4 climb up. The bearers then carry the stretcher on.

10. On no account should a stretcher be permitted to be carried on the shoulders of two or four bearers. The evil of such a proceeding is not only that it is difficult to find several bearers of precisely the same height, so that a level position may be secured, but also that the wounded or sick person, if he should happen to fall from such a height, owing to the helpless condition in which such a patient usually is, is not unlikely to sustain a serious aggravation of the injuries he may already be suffering from. Moreover, one of the bearers of a stretcher ought always to have his patient in view, so as to be aware of hemorrhage, fainting or other changes requiring attention taking place, and this cannot be done when the patient is carried on the shoulders. The height, too, is calculated to cause the patient uneasiness and fear of falling off, which is also desirable to avoid. For all these reasons, notwithstanding that bearers will often attempt to carry a patient on a stretcher upon their shoulders from the weight being borne more easily in that position or with a

view of relieving a fatigued condition of the arms, the practice should be strictly forbidden.

Special care should always be taken to notice the part injured and the nature of the injury, as these determine in a great measure the position in which the patient should be placed during transport. In all cases the head should be kept low, and on no account pressed forward on the chest.

In wounds of the head care should be taken that it is not placed so that the injured part presses against the conveyance.

In wounds of the lower limb the patient should be laid upon his back, inclining towards the injured side—such position being less liable to cause motion in the broken bone during transport in cases of fracture.

In wounds of the upper limb, if the patient requires to be placed in a lying-down position, he should be laid on his back or on the uninjured side, as in cases of fracture there is less liability in such a position of the broken bones being injured during transport.

In wounds of the chest there is often a difficulty of breathing. In such cases the patient should be placed with the chest well raised, his body at the same time being inclined towards the injured side.

In wounds of the abdomen the patient should be laid upon the injured side with his legs drawn up, or if the wound be in the front of the abdomen, he should be placed upon his back and his legs drawn up, so as to bring the thighs as close to the belly as possible; a pack or other article being placed under his hams to keep his knees bent.

(Manual for the British Medical Staff Corps, page 115, 1885.)

### TRANSLATIONS.

**DANGER FROM LAVAGE IN LAPAROTOMY.**—I have observed many times that, at the moment when hot water was introduced into the abdominal cavity to wash away foreign substances, the patient's respiration weakened. In two cases I have seen the respiration completely arrested at the precise moment when the hot water was injected. In these cases the function was re-established

with considerable difficulty; but in a third case the patient died one hour after the operation, of failure of the respiration.

This danger seems to exist only when the hot water laves the under surface of the diaphragm or the region of the solar plexus; when it provokes, by reflex action, the arrest of respiration and syncope.

When the patient is allowed to lie on the back in such a manner that the hot water can flow up to the diaphragm, this accident may occur. If the temperature of the water be above that of the body, the impression will be greater. —POLAILLON, in *Bull. de l'Acad. de Méd.*

**ACTION OF YEAST FUNGUS.**—Dr. Heer, Ratibor, *Deutsch. Mediz. Zeitung*, contributes the following in regard to the action of the yeast fungus in infectious diseases:

1. "During the present extensive and malignant epidemic of scarlatina and diphtheria in Ratibor (now disappearing), I have used beer yeast to the exclusion of every other remedy, and have attained a success as with no other known method. The exanthema runs a mild course with very little fever, while in diphtheria, as a rule, the separation of the exudate follows in a surprisingly short time, and the danger of heart-failure and paralysis, in every case is warded off. As a medium dose I recommend half teaspoonful every hour, together with washing out of the throat and mouth every two hours with yeast 1 part and water 5 parts. Diarrhoea or other unpleasant effects never occurred, rather a restoration of the appetite and normal digestion.

2. "In the diarrhoea of infants, with whom the dejections are rotten, of bad color and loaded with bacteria, brewer's yeast is an incomparably active remedy. It is best administered diluted with light beer (1 to 5) in doses of 2 to 4 drops every hour.

3. "In all cases of typhoid fever treated by me with the yeast, the diarrhoea has ceased in a short time.

4. "Sanitary counsellor Dr. Hufschmidt treats since four weeks ago in the hospital of the 'charitable brothers' at Pilchowitz several cancer patients with yeast; he reported to me several days

ago that the success is a visibly favorable one. Sanitary counsellor Dr. Ventura, of Teplitz-Trenchin, has accomplished the complete cure of carcinoma of both breasts in one of his patients. I myself have been able to bring about the cure of an epithelioma of the tongue at the penal institution of this place. The yeast is applied both internally and externally.

"Accordingly, it is no longer to be doubted that yeast is calculated to prevent the existence and proliferation of the pernicious kinds of fungus multiplying by division (*Spulnpilze*), without doing the slightest damage to the human organism.  $1\frac{1}{2}$  liter (3 pints) of fresh, not over 3 days old, *under* or *bottom* fermentation beer-yeast may be given per day without the slightest hesitation."

**TREATMENT OF PHTHISIS.** Dr. J. Rosenthal, of Königsberg, treats phthisis pulmonalis as follows: Bottles of the capacity of  $\frac{1}{4}$ ,  $\frac{1}{3}$  and  $\frac{1}{2}$  liter are procured, which, for convenience sake, are named  $\frac{1}{4}$  bottles,  $\frac{1}{3}$  bottles and  $\frac{1}{2}$  bottles, and these are filled with carbonic acid water (soda water), together with creasote and cognac in the proportion as follows: the  $\frac{1}{4}$  bottle (=  $\frac{1}{8}$  liter = 1 minimum dose) contains creasote puriss. 0.10 and cognac 5.00. Some  $\frac{1}{3}$  bottles contain a double amount of creasote (creasote 0.20 and cognac 5.00). The  $\frac{1}{2}$  bottles contains creasote 0.40, cognac 10.00, and the  $\frac{1}{2}$  bottle creasote 0.60 and cognac 15.00.

In order to attain the now generally recommended daily dose of 0.80, gradually increasing, let the patient take a  $\frac{1}{4}$  bottle (creasote 0.10) immediately after dinner the first day. On the second day and during the rest of the week, he takes such a  $\frac{1}{4}$  bottle both after dinner and after supper. With the second week he begins with the stronger (creasote 0.20) water, and so uses the  $\frac{1}{4}$ ,  $\frac{1}{3}$  and  $\frac{1}{2}$  bottles after each meal, week after week, as to increase the dose of creasote by 0.10 each day, until the maximum of 0.80 per day is reached, which is  $\frac{1}{2}$  and one  $\frac{1}{4}$  bottles (creasote 0.20).

Patients who are recommended to use wine after the method applied by Dr. Brehmer and Dr. Detweiler, may

mix with it the creasote mineral water, since it improves the taste of the latter.

Dr. Rosenthal insists that in the preparation of creasote mineral water there be selected none other than especially purified, entirely fresh beechwood creasote, almost as clear as water, which contains no carbolic acid.

Where there is tendency to hæmoptysis, which is no contra-indication to its use, because it is proved experimentally that its action increases the coagulability of the blood, it is proper to allow part of the carbonic acid to escape by opening and shaking the bottle.

Dr. Rosenthal lays stress upon the following points:

Creasote thus prepared is so easily taken, so well borne and readily digested, that patients, when once used to it, deem it a refreshment; it can therefore be administered in constantly increasing doses for a long time without interruption—an important consideration.

Cases unfavorable to its employment are those whose temperature is above  $38\frac{1}{2}^{\circ}$  C. ( $101\frac{3}{4}^{\circ}$  F.). Yet even here, in spite of the fever, the effects of the remedy upon the gastric and intestinal digestion are so favorable as to enable the economy of the organism the better to resist the deleterious influence of increased temperature, until, thanks to the antimycotic action of the remedy sterilizing the soil upon which the bacilli grow, the effect is removed with the cause.

Initial cases of consumption are most amenable to treatment by this method. The fact must be emphasized however that the treatment must commence early, must be continued for a sufficient length of time (several months) without intermission and in gradually though constantly increasing doses, and must not be hindered or prostrated by irrational and health-destroying modes and habits of life. "*Qui bene diagnoscit, bene curat.*"

It may be expected that carbonic acid creasote water will be of use in the treatment of scrofulosis; Sommerbrodt has seen greatly enlarged lymphatic glands of the neck in youthful individuals to disappear, after all other medication had proved inefficient.

The enthusiastic Reuss recommends its use in chronic bronchitis, and during

convalescence from other affections of the air-passages.

The good effects of creasote mineral water are noticeable already during the first few weeks, and are manifested by increase of appetite, diminution of expectoration, disappearance of cough, softness of breath and thoracic pain, and increase in weight, from 3 to 5 pounds in the most unfavorable, and from 20 to 30 pounds in the most favorable cases.

Although this treatment is urgently to be recommended to those who can avail themselves of the therapeutic help of mountain climate, proper nourishment, fresh air, general exercise, pulmonary gymnastics, etc., it is of particular benefit to those who have not these advantages, but are compelled to undergo treatment at home, or the asylum, or the hospital.

—*Berl. Klin. Wochenschrift.*

#### BEAN FLOWERS IN NEPHRITIC PAINS.

—One of my patients having been relieved of nephritic colic by an infusion of the dried flowers of the Windsor bean, I advised their employment in a number of cases, with the following results:

1. A case of subacute nephritic colic with phosphatic and uratic gravel; a repeated attack; the pains were always relieved by one or two cups of the infusion, at intervals of a quarter hour.

2. Two cases of nephritic colic with sandy gravel, alternately acute and subacute; the infusion taken at the start prevented the vomiting.

3. A case of nephritic colic symptomatic of renal calculus.

4. A case of nephritic pain, acute or subacute, with chronic cystitis from enlarged prostate.

5. Acute nephritic colic in a diabetic woman. The infusion, given after the vomiting began, had no effect. This colic had lasted three days, and resisted four injections of morphine.

In five of the above cases favorable results followed the use of one or two cups of infusion, each cup containing fifteen or sixteen flowers.

—BOULOUÏE, in *Revue de Thér.*

#### TREATMENT OF TYPHLITIS.

BOUCHARD (*La France Méd.*) gives

the following directions: 1. Allay the pain by an injection of morphine, or by a thick layer of Neapolitan belladonna ointment, covered with a large, very hot poultice. 2. Empty and render aseptic the large intestine by large intestinal irrigations, twice daily, with at least a liter of water at 38° cent., to which is added five grammes of soda borate, and two or three teaspoonsfuls of tincture of benzoin and tincture of camphor, equal parts. The irrigations must be given gently. 3. Absolute rest. 4. Little purgative medicine; none but the mildest, such as magnesia in *eau sucrée*. 5. For food, milk with alkaline water, a little at a time; later, the yolk of an egg.

SCHMITT and SPILLMAN (*Revue de Thér.*) recommend the application of ice in orchitis, finding it easy, practical and sure, suited to all forms and all stages; relieving the pain quickly, and speedily bringing on resolution, which may be completed by the use of styptics, astringents and suspensories of elastic webbing.

#### FOR UTERINE COUGH.

If the cough coincide with troubles of the cerebral circulation, heat of the face, vertigo and oppression, give the following:

Infusion of black coffee. 120 grms.

Simple syrup. . . . . 40 grms.

Valerianate of caffeine. . 1 grm.

Two or three spoonfuls daily, one-half hour before eating, or two hours after.

If the cough recur only at night, or at regular intervals, give:

Valerianate of quinine. .1 gramme

Extract of cinchona, q. s.

Divide into twenty pills. Take one after each meal.

For those who have attacks of convulsive hysteria:

Valerianate of zinc. . . . . ½ gramme

Extract of valerian, q. s.

Divide in twenty pills. One at each of the two principal meals.

If there exists a decided neuropathic state:

Valerianate of ammonia, 3 grains

Gummy julep. . . . . 120 grammes

Take a spoonful every three hours.

Such local uterine treatment should be employed as is indicated in each case.—CHERON, in *Revue de Thér.*

PHILADELPHIA  
MEDICAL TIMES.

PHILADELPHIA, OCTOBER 1, 1888.

## EDITORIALS.

## NEGLECT OF PUBLIC DUTIES.

IN Mackenzie Wallace's book upon Modern Russia, he illustrates the effect of engrafting an alien civilization upon a people who as yet are hardly advanced enough to know what to do with their borrowed culture. In the communal assemblages, when a member reads an essay upon some subject, his material is drawn from the cyclopædic works of German authorities. But when the author takes leave of his German masters and comes to the practical application to the conditions before him, he is lamentably weak; a few brief and timid sentences, and he is done. His erudition is immense; his library is great; but his powers of observation and deduction are dwarfed.

The inevitable result is that the culture does not succeed; in spite of the fostering care of the government, the communal lyceums languish, because they are not in accord with the true needs of the people; they lack vitality.

Something of the same sort appears to exist here. We have just had an assemblage in Washington of several hundreds of the most eminent physicians in America; men who are held to represent the highest development of culture in the art of healing. The yellow fever grows daily more threatening in our Southern States, where the people are becoming terrified at the spread of the disease. What is more natural to expect than to look to this body of great men, assembled almost under the shadow of the pestilence, for help in their time of need? But with the exception of a brief talk from Dr. Stern-

berg, with no discussion of any moment, the subject was ignored. Whether the distinguished physicians at that meeting had no information at their disposal upon the matter, or whether the sufferings of the South simply failed to interest them, we know not; but we may safely say that this meeting was not in accord with the needs of the day. Even if no new or valuable ideas had been promulgated, the knowledge that their troubles had been taken up, and were being considered by this august assemblage, would have done good in checking the panicky feeling in the Gulf States.

The first meeting of the County Medical Society, after the summer recess, was held on September 12th. But few of the members were present. With the typhoid fever unusually prevalent in this city, one would have thought that home interests deserved some attention from what is probably the most scientific body of physicians in America. Not so much as a passing remark was made on the Southern scourge, or the ugly shape at our elbows; but some one made inquiry about the malady of the late Emperor of Germany.

Such a state of affairs may be contrasted with the work of the Academy of Medicine in Paris. An outbreak of any epidemic disease would be the subject of inquiry there. Whatever concerns the public health, such as the contagiousness of alopecia in school children, is discussed at length, an elaborate report submitted, and the authority of the Academy is given to the conclusions reached. Naturally, the public looks to this body as the proper one to give advice in affairs of this kind, and the Academy fulfils a public need and possesses influence in the body politic, which insures the support of government and people.

How much influence has the regular

profession here in public matters? It is notorious that if a State Board of Medical Examiners were appointed, the irregulars would be quite as likely to be found in it as the regulars. If quackery is rampant and the regular profession fails to hold the same influence it does in other countries, it is ourselves who are to blame. When the people see us watchful of their interests, understanding their needs and capable of supplying the remedy, there will be no lack of support. Too much study of foreign masters, and too little attention to the duty that lies nearest our hands, too much compilation and too little independent investigation, too much wire-pulling and too little leadership are the reasons which make our profession so little influential in the community.

#### VOLUME XIX.

**T**HE present number inaugurates the beginning of the nineteenth volume of the *MEDICAL TIMES*—the second under the present management. What we have accomplished during the past year may be seen by a reference to the Index, which shows how fully every department of medical science has been covered.

It will be seen that while we make Philadelphia medicine our special study, we do not confine ourselves to our own city, or even our own country.

We will endeavor through the coming year to give one Clinical Lecture in full in each issue, besides the notes from the Philadelphia clinics which have proved a popular feature of the journal.

An effort will be made to report the society proceedings in the same manner as the clinics.

The Translations and Abstracts will be continued in the present form. It is obviously impossible for any journal to republish in full all the valuable

matter which appears in its contemporaries. Medical readers are of two classes: first, those who prefer to have their subjects elaborated, and who can sit down and digest a lengthy studied article at their leisure; and, second, the busy men who have no time for such reading, but want the gist of the matter at once; who are in active practice and care more to relieve their patients' suffering than to know what Hippocrates thought about a subject. We endeavor to reach the needs of the second class, as those who are sufficiently interested in the matters can always send to the journals from which we quote and obtain the articles in full.

The foreign letters of Drs. Williams and Linn will be continued as usual.

Especial attention will be paid to the Reviews and Book Notices.

Under the head of Annotations will be included minor editorial notes and such abstracts as receive editorial comment.

The only department which has proved a disappointment is that of Letters to the Editor. We hope to see under this head a free interchange of opinion among our readers, which would bring the journal more in support with its clientele, and foster a spirit of inquiry which would bring forth useful results.

It is good for one to put his thoughts upon paper, even if only that he may clearly comprehend what his thoughts really are; the labor of getting up a presentable paper is sure to bring its reward.

We hope that our friends will assist us in developing this part of our journal. Without such a means of keeping the hand upon the pulse of the profession, a journal is apt to degenerate into a mere record of medical curiosities; like our friend the Medical Museum, in whose contents the practitioner is interested about as much as he is in the Ruins of Babylon.

The TIMES appears in a new dress, in that the cover is omitted. Our readers are of a class who look more to the inside of a journal than the outside; and we have felt that the cost of the cover could be more profitably employed in increasing the number of our reading pages, and the quality of the matter contained in them. We are also enabled to reduce the price of the Binders.

The policy of the TIMES will be to fulfil the object with which it was founded—that of furnishing a journal representative of the Philadelphia medical profession in its entirety, and not of any particular school, society or clique. Our efforts will be directed to the restoration of harmony among our medical neighbors, and the discouragement of the petty strife which has annoyed the earnest workers in scientific circles during the past few years.

The Departments of the TIMES will be as follows:

Clinical Lectures.  
Original Articles.  
Translations.  
Notes from the Philadelphia Clinics.  
Editorials.  
Annotations.  
Foreign Letters.  
Society Proceedings.  
Letters to the Editor.  
Reviews and Book Notices.  
Abstracts.  
Miscellany.

### ANNOTATIONS.

THE *Lancet* and the *British Medical Journal* come to us this week in the form of Student's Numbers. The latter is a huge mass containing seventy-two quarto pages of small print reading matter and one hundred and four of advertisements. Full information is given concerning the requirements, fees and curricula of all the medical colleges in the United King-

dom. There are sixteen corporate bodies which have the licensing power, three of which are to be found in London; while of *teaching* schools there are eleven in London alone, and twenty-three more in the provinces. Thus, there are fifty institutions engaged in the work of furnishing recruits for the medical profession. Twenty-three London hospitals, in addition to those already enumerated, assist in educating the student, with private schools, tutors and quizzes innumerable. Surely, with all these opportunities, the British medical student ought to be reasonably sure of obtaining an adequate medical education. And yet, whether from the severity of the examinations, the absence of the faculty of imparting knowledge, or the inherent stupidity of the young Briton, we see in the *Medical Press* that one of the colleges only succeeded in passing fifty-five per cent. of its applicants. This was in an Irish college, too, where the requirements are said to be lower than in England.

As it is, many British students cross the channel to Brussels, where, their examinations being carried on through the medium of an interpreter who possesses a thorough knowledge of medicine, the acquisition of a degree is the reverse of difficult.

Among the text-books recommended we note those of Bartholow, Napheys, Stimson, Stephen Smith, H. C. Wood, Flint, Pepper's System, Lusk, and Duhring. The first named is a surprise, as after the very sharp criticisms of this book by the British medical journals, one would hardly expect to see them recommend it. The fact that so many works by American authors are to be found in this list shows something more than a mere international courtesy. Were these works not thought to be suitable for the students' use, no such recommendation would be given. Science is cosmopolitan; she is greedy for truth; and seeks to ingest it wherever found.

### IMPLANTATION OF TEETH.

FOREIGN journals report adversely upon this operation, stating that the only connection between the tooth and its socket is fibrous; processes from the latter penetrating the interstices of the im-

planted tooth, which remains a lifeless foreign body.

In an editorial in the *Independent Practitioner*, Dr. Sudduth says, "Sufficient time has not elapsed since the operation was first introduced to allow of a final verdict. Dr. Younger's ideas regarding the method of attachment were crude. The theory of revivification of the pericementum was so utterly absurd, that but for the fact that teeth so implanted could and did become firmly set in the jaw, it would have overthrown the operation.

"The plasm cells first thrown out become organized, and a firm connective tissue envelops and encircles the root. The fine processes of the cells probably penetrate the superficial lacunæ of the cementum, and in this way help to attach the tooth more firmly than would be the case with a porcelain tooth. Such may be said to be the manner of attachment at the end of the first week or ten days after operation; but a second stage intervenes, provided the inflammation is kept in abeyance, when the process of ossification sets in and proceeds until the socket is filled with new-formed bone, giving rise to a bony ankylosis.

"No experiments have been made to demonstrate the truth of this latter statement; but the solidity with which the teeth become attached, their lack of mobility and the peculiar resonance when such teeth are tapped, all tend to confirm our opinion regarding the nature of the attachment in successful cases."

#### THE NEW BUILDING OF THE PHILADELPHIA LYING-IN CHARITY.

THE new building of the Philadelphia Lying-in Charity, at the southwest corner of Eleventh and Cherry Streets, is now open for the reception of patients. There are ten private rooms for the care of obstetric patients, and room in the maternity wards for twenty-five charity patients. An isolated portion of the building containing six private rooms and two wards, each with a capacity of five beds, is reserved for the treatment of diseases peculiar to women. Every deserving case of tumor of the abdomen or breast, in destitute circumstances, is admitted free of

charge. A daily clinic for the treatment of diseases of women is held at twelve o'clock. A nurse directory is attached to the institution, from which nurses are furnished *immediately* at any hour of the day or night *without charge*. Unmarried women are admitted only for their first confinement.

The new building is a model of hospital construction; every improvement of a modern character for the safety, aid and welfare of the patients has been provided. The appointments and equipment are unsurpassed by any institution of the kind in the country. A separate nurse is assigned to each private room. All the rooms have large windows, open fireplaces and electric bells.

Dr. Charles Meigs Wilson is the surgeon in charge. All letters relative to the admission of patients should be addressed to him at the hospital. The consulting obstetricians are Dr. Elwood Wilson, Dr. Theophilus Parvin and Dr. W. H. Parish; the consulting surgeons are Dr. D. Hayes Agnew, Dr. Samuel W. Gross and Dr. John B. Roberts.

The editor of the *Memphis Medical Monthly* asks the question, "Did Memphis do right in rejecting the yellow fever refugees?"

We should hardly imagine there could be more than one answer possible. Memphis has proved to possess the conditions suitable for the cultivation of the yellow fever germ. She is a large and important city, from which an epidemic might be carried to many other places. The observance of the utmost precaution to prevent the entrance of yellow fever would seem to be her first duty to the country at large. There are many other cities of refuge for those fleeing from the Florida terror, where no possible danger exists of the disease taking root. Memphis, Pensacola, New Orleans and Shreveport may, with propriety, be allowed a strict quarantine.

DR. SANSOM, of London, gave a brief address at Blockley on Saturday, September 22. He exhibited his "pleximeter," which excited much interest. It consists of a T-shaped piece of hard rubber, small enough to go in the vest-

pocket. The large cross-piece is held against the chest by two fingers, and percussion made upon the smaller cross-piece. The sound is much more clearly defined than when the percussion is made against the finger.

In examining the chest, it is Dr. Sansom's custom to mark the outlines, etc., upon the chest in oil. A piece of soft paper is then held against the chest, and the oil marks traced in pencil. This sheet is then labeled with the patient's name, etc., and filed away for future reference.

WHY should *The Practitioner* refer to an editorial in the *TIMES* as by an "anonymous writer?" Editorials are written by the editor, and when they are contributed, have the initials of the writer appended.

### LONDON LETTER.

**I**N spite of most unseasonable weather—cold and wet—London continues very empty of interest, as nearly everybody who can get away is vegetating in the damps of the country or seaside, or searching for finer weather on the continent of Europe. There are long vacation classes at Cambridge; but in London, not only the medical schools but the societies have suspended all work, and will not resume until probably this letter is in type. The medical schools will open on October 1, and, in about a moiety, introductory addresses will be given; though I do not anticipate that any of them will be of unusual interest, unless Professor Ericksen, F.R.S., who has recently become President of University College, finds something important to say to the students of the sister institution of King's College. Probably he will make a statement with regard to the agitation for a new university in London. Rumor says that the members of the Royal Commission, which has recently suspended its sittings for the vacation, have shown that they have a strong bias in favor of creating such a body. If so, we are probably only at the commencement of a long struggle, for the two colleges of Physicians and of Surgeons in London will fight hard to maintain and extend their present ascendancy.

### A FRACTURE IN POLITICS.

A curious pathological question is likely to engage the attention of the Council of the British Medical Association at an early date, under very unusual circumstances. It has arisen in connection with an unfortunate conflict in British Guiana. The chief industry of that colony is the production of sugar, which is carried out on a large scale by wealthy planters, who employ large numbers of coolie laborers, imported chiefly from Hindostan. For the protection of these coolie laborers, the government promulgated some years ago an ordinance prescribing, among other things, that the huts for their use should be constructed and maintained with proper regard to sanitary requirements, and that adequate hospital accommodations should be provided on the estates for sick coolies. By subsequent ordinances a medical service was organized under a surgeon-general, and the duty of inspecting the hospitals was transferred from the "immigration service" to the medical service. A good deal of friction arose in some way, and recently matters have come to a crisis. In consequence of a report made by the medical inspector of hospitals, Dr. A. D. Williams, an agitation arose in the colony which has already resulted in the removal of that officer from his post. Some months earlier, however, a difficulty of a different kind had arisen, which divided many members of the medical service into two opposing camps. A coolie named Nepaul, who had been in an estate hospital for some weeks or months, was sent up to the Public Hospital, Georgetown, and on examination there it was found that he was suffering from a large abscess of the thigh connected with the femur, which was fractured. The medical officer of the estate hospital was removed from his position on suspicion of negligence by Dr. A. D. Williams, who was then acting as surgeon-general in the absence on leave of the surgeon-general. An inquest was held, and there was discovered a great difference of opinion among the medical witnesses as to whether the femur had been diseased or fractured; whether in fact the case was one of simple fracture complicated by abscess, or of suppu-

tive osteitis and periostitis. Abscess is, so far as I can ascertain, an extremely rare complication of simple or comminuted fracture, though not unknown. The branch of the British Medical Association in British Guiana has referred the whole controversy to the Council in London, and has, it is reported, requested that the opinion of the pathologist to the Royal College of Surgeons may be taken on the bone. People are curious to see what the Council of the British Medical Association will do under these novel circumstances; in which they will, it is said, have no precedent to guide their action.

#### THE BRITISH MEDICAL ASSOCIATION.

The invitation to hold the next meeting of the British Medical Association in Leeds has been accepted, and the Association will assemble there in the first week in August, 1889, under the presidency of Mr. Claudius Galen Wheelhouse. Mr. Wheelhouse was formerly the President of the Council of the Association, and his great popularity with the profession is shown, among other evidence, by his having been elected by the practitioners of England, at the head of the poll, as one of the first elective members of the General Medical Council, an office which he still holds. The meeting is likely to be exceedingly successful, especially in point of numbers, as Leeds is a convenient centre for the densely-populated manufacturing districts of Yorkshire and Lancashire.

#### ACUTE OR CHRONIC.

The statements made by politicians as to the cause of the death of Mr. Mandeville, the Irish agitator, afford another example, if one were wanted, of the extraordinary ignorance of the public about medical matters. Mr. Mandeville died of angina ludovici; and it was seriously contended and very widely accepted that this acute disease was due to his sufferings while in prison, some months before, and was in some way connected with a slight sore throat he then had. As to the sufferings and privation endured, it may be observed that Mr. Mandeville weighed 227 pounds when committed to prison, and 224 when discharged from prison.

#### CONSTIPATION IN INFANCY.

Constipation in infants and young children is a fruitful source of discomfort to the patient and of anxiety to the mother or nurse; and it is well to draw attention to a complication sometimes produced, which tends to aggravate and perpetuate the constipation. This is superficial fissuring of the anus. When it is said that the infant passes large infrequent motions and cries much during defecation, it will not infrequently be found, on inspecting the anus, that it is spasmodically contracted; and on gently everting it, a shallow "crack" or fissure may often be seen. The fissure has probably been produced in the first instance by the passage of a large constipated motion, and the pain subsequently caused every time the bowels are opened tends to induce the child to avoid the operations as much as possible. The motions then become habitually large as well as hard. The constipation itself is generally in the first place to be traced to errors in diet, the food containing too little fluid or being of too bland a nature. Some of the foods now to be obtained are so soluble and contain so little waste that the digestion must be completed at a very early stage, and almost the whole absorbed. The main indication is to give attention to the diet and regimen of the child, and especially to vary the food.

For the local treatment of the constipation, I believe that nothing equals the injection of small clysters of glycerine. About half a drachm gently thrown in with an ordinary syringe is followed in a few minutes by a satisfactory motion; and if at the same time the diet is improved, it will soon be found that the glycerine may be dispensed with. Dr. Eustace Smith confirms this recommendation, and any one who may be induced by his high authority to try the method will be gratified by the result. Where diet reform alone does not suffice after a short time to bring about natural evacuations, he recommends the following:

R Tinct. nucis vom. .... M ss  
Tinct. belladonnæ. .... M x  
Infusi sennæ. .... M xx  
Infusi calumbæ. .... ad 3 j

This may be given thrice a day at

first. After a time, two doses will be enough; and before long, one dose at bedtime. An equally good or better prescription is:

R Tinct. nucis vom. .... ℥ ss  
Ext. cascariæ sagradæ liq. ... ℥ xx  
Tinct. belladonnæ ..... ℥ j  
Inf. calumbæ ..... ad 3 j

The keynote is the combination of nux vomica with belladonna and some gentle laxative. Dr. Eustace Smith also recommends, where the motions are very dry, a saline aperient:

R Quinæ sulph. .... gr. 4  
Acid. sulph. aromat. .... ℥ j  
Tinct. nucis vom. .... ℥ ss  
Aque ..... ad 3 j

This for a child of six months.

#### CHARCOT'S JOINT DISEASE.

During the last session of the Pathological Society, Dr. Collier, of Oxford, exhibited specimens from a remarkable case of Charcot's disease coming on at a late period of locomotor ataxy. The history of the case proved conclusively that the joint changes could not have been due, in this case at any rate, to the use of anæsthetic and inflamed joints, inasmuch as the articular lesions came on under observation, while the patient was bedridden. The spinal cord in this case was examined by Dr. G. N. Pitt, who found extreme sclerosis of the root zone of the postero-external columns, and of Goll's columns, and diffuse sclerosis of the rest of the posterior columns. He also found marked sclerosis of Clarke's columns on the right side—the opposite side, it is true, to the joint affection—but an observation, nevertheless, of considerable interest when viewed in the light of Dr. Gaskell's discoveries, of which mention was made in a previous letter.

#### PROPOSED QUINQUENNIAL CENSUS.

A movement has commenced among sanitarians which has for its object, to induce the government to authorize a quinquennial census, in place of the present decennial census. A memorial recently presented to the Local Government Board by the Council of the Statistical Society states that a quinquennial census is already held in twelve States and three territories of "the American Republic," as well as in several British colonies. The main ground on which it is desired here is that it would be more accurate to have

an actual enumeration in place of the present estimates of population, when calculating the death-rates and birth-rates of sanitary districts.

#### SIR WILLIAM BOWMAN.

A committee has been formed to raise a fund in order to present a portrait of himself to Sir William Bowman, Bart., F.R.S., as a public acknowledgment of his services to ophthalmology and physiology. Dr. George Johnson, F.R.S., of Saville Row, London, W., Emeritus Professor of Medicine in King's College, is the treasurer of the fund.

#### RECTAL ANÆSTHETIZATION.

Rectal alimentation being now a well established procedure, rectal medication appears to be attracting more attention; and I notice that satisfaction is being expressed by practitioners who have administered ether by this channel. The last report which I have seen is by Dr. F. H. Appleby, of Newark, who gave it to a woman, aged 29, with complete success. The operation was the extraction of twelve teeth. The dentist began to operate in four seconds less than eight minutes after the commencement of the administration. No more ether was given after the first ten minutes—but four teeth were extracted subsequently—the operation lasting fifteen minutes altogether. Six minutes later the patient was able to walk with assistance. The quantity of ether used was large: fourteen drachms.

#### RHEUMATIC GOUT.

The distinction between gout and rheumatism is not always very clear, and perhaps not always possible. Cases of chronic rheumatism constantly come before us in which there is a gouty family history, and in the treatment this family history must not be ignored. The following prescription, though inelegant and unpalatable, is an extremely useful combination where anæmia is a marked symptom, as is often the case.

R Quinæ sulph. .... gr. iij  
Ferri et ammon. citr. .... gr. v  
Lithiæ carbonatis. .... gr. v  
Pot. citratis. .... gr. v  
Pulv. tragacanth co. .... gr. x  
Tinct. lavandulæ co. .... ℥ xv  
Aque ..... ad 3 j

To be taken in a wineglassful of water, thrice a day.

DAWSON WILLIAMS.

# THE FIRST TRIENNIAL CONGRESS OF AMERICAN PHYSICIANS AND SURGEONS.

IN the city of Washington, D. C., on Sept. 18, 19 and 20 ult., the following National medical organizations assembled by preconcerted arrangement: The American Surgical Association, the American Association of Genito-Urinary Surgeons, the American Laryngological Association, the American Climatological Association, the Association of American Physicians, the American Otological Society, the American Ophthalmological Society, the American Neurological Association, the American Dermatological Association, the American Physiological Society, and the American Orthopædic Association. As it was the intention to have a similar congress every three years, the present meeting was styled the First Triennial Meeting. Owing to the fact that some of the Associations were in the habit of meeting at another time of the year or from other reasons, a few of the special organizations did not participate in the Congress; and one, the American Gynecological Society, had decided at first not to attend, but shortly before the meeting it reversed its first decision, and was admitted to the Congress; but for its tardiness was punished by having its proceedings omitted from the official programme. This was a grave error on the part of those having the matter in charge, since the Gynecological Society is one of our oldest and best special organizations, and its published proceedings contain valuable contributions second to none in its special department, and which are universally admitted to be an honor to American medicine. The kindred association formed recently at Buffalo, bearing the rather formidable title of the American Association of Gynecologists and Obstetricians, held its first annual meeting at Washington during the session of the Congress, but was rather arbitrarily refused permission to participate, owing to the fact that it was not yet two years of age; but as this rule did not apparently exclude the newly formed Orthopædic Association, the Anatomical Association or the Physiological

Association, each of which held their first annual meeting this year, it is evident that some other cause than the one assigned was operative. We believe, however, that no reflection was intended to be made against the personal or professional standing of the men who have organized the new association, and who appear to be quite able to carry it on successfully without the patronage of the great abstraction, which, by the way, stands unique among medical congresses, *nomen et præterea nihil*. It is peculiar in the fact that it has nothing approaching a permanent organization, being conditioned upon the voluntary assembling at the National capital of various special associations once in three years, anyone of which may find it more convenient to hold its meeting elsewhere at the time designated for the holding of the next Congress. It is also peculiar in that while it has officers it has, properly speaking, no members, its membership consisting in those belonging to the constituent societies, who happen to be in attendance at the time, and who on the first day of the Congress elect the officers. It is evident that a medical organization as loosely constructed as this should exercise great discretion in any attempt to legislate for the medical profession, especially in the direction of exclusivism. We question, therefore, very much its right to refuse admission to the triennial meeting of any organization of regular and reputable physicians, instituted for the investigation and advancement of any department of medicine, who may desire to participate, whether such society have been in existence more or less than two years, and whether there be a similar organization in existence in this country or not. It is true that there is authority for the statement that the wise men came from the east, but it is not recorded in history that they remained there; and since no portion of this great Republic can claim a monopoly of medical wisdom, it is to be hoped that the next Triennial Congress of American Physicians and Surgeons will have meeting fraternally with it Western and Southern special medical organizations as well as those claiming to be National in character;

but really almost exclusively representing the medical men and medical colleges of the East and North.

For reasons stated above the Congress could not claim any attendance other than the members of the several societies' meeting conjointly, of which there were present some 250 or more. At the meeting for organization on the first day at noon, John S. Billings, M. D., U. S. Army, who had been nominated by the Executive Committee (a committee consisting of representatives of the different societies), was elected president of the congress; the presidents of the various special organizations first named, were announced as vice-presidents *ex-officio*. Dr. William Pepper of Philadelphia was made chairman of the Executive Committee; Dr. W. H. Carmalt of New Haven, Conn., was appointed secretary and acting treasurer.

The special organizations held their meeting (at which the usual programme of the annual session was followed) during the morning and afternoon, while the evening was devoted to a general meeting of the Congress. It was inauspicious, to put it mildly, that the banquet (to which members as a privilege were permitted to contribute twenty dollars), was a dismal failure, although it occurred on the eve of the meeting. The menu was elaborately printed, but most villainously served, for which, however, we would exonerate the committee in order to put the blame where it belongs, with mine parsimonious host of Willard's. It is fortunate for the reputation of American cooking with our foreign guests that they had the opportunity of forming a more favorable estimate of our cuisine at a number of private receptions and dinners in Washington, Baltimore, Philadelphia and New York before their departure.

Among the distinguished guests, were Esmarch and his royal bride, the Princess Henrietta, Sir Spencer Wells, Sir Reginald Harrison, Sir William MacCormack, Victor Horsley, David Ferrier, Dr. Durham, of Guy's, Dr. Ord, Dr. Lavista, of Mexico, and Dr. Priestley, who was accompanied by Mrs. Priestley, whom Dr. Pancoast pronounced charming enough to be an American lady.

The first evening meeting was devoted to Intestinal Obstruction in its Medical and Surgical Relations, the discussion on which was opened by Reginald H. Fitz, of Boston, and continued by Nicholas Senn, Wm. Pepper, W. H. Draper, J. Collins Warren and others. The next evening was devoted to papers on Cerebral Localization in its Practical Relations, by Chas. K. Mills, of Philadelphia, and Roswell Park, of Buffalo, who were followed by David Ferrier, Victor Horsley, M. A. Stan, W. W. Keen and others. The subject was treated in an extremely interesting manner, and the discussion will form a most valuable contribution to the medical and surgical relations of brain surgery. The final evening meeting was held in the new hall of the National Museum, in the Smithsonian Grounds. John S. Billings, M. D., U. S. A., delivered the president's address, "On Medical Museums," which was followed by a general reception in the United States Army Museum Building which was in full holiday attire for the occasion. Among the entertainments we must include a special informal reception given by the President of the United States and Mrs. Cleveland, which was considered a marked distinction by the foreign guests, who have returned to their homes much pleased with their brief visit to the capital city. The programmes of the several societies were very full, and altogether a most favorable impression must have been given to all of the state of medical science in this country, and of the energy and ability displayed by the special societies who are so diligently engaged in tilling the common field, whose motto is *laborare est ovare*.

SCRIPSI.

#### CONGRESS ECHOES.

Washington, Sept. 21, 1888.

**T**HE first Congress of American Physicians and Surgeons adjourned last night in a blaze of glory. As a scientific meeting it was an unqualified success. The details of the work done will be given in other columns with sufficient fulness. It is intended to note here only a few personal and social matters.

The big twenty dollar dinner on Monday evening was a dismal failure. How any body of men having the intelligence of the committee having this affair in charge could have shown so little gumption as this committee did passes all comprehension. In the first place the dining-room at Willard's, where the dinner was served is the most gloomy and unattractive that could be imagined; secondly, the table and service at this hotel are not especially notable for excellence; thirdly, the selection of speakers was not particularly happy, and fourthly, the whole affair was so stupidly managed that everyone was glad when it was all over, though doubtless many regretted that they got so little enjoyment out of it.

Of the foreign guests, Prof. von Esmarch, with his strong features covered but not obscured by a snow-white double-peaked beard, received most attention. Possibly the fact that he was the consort of a Princess Royal had some influence in securing him this prominence. His speech at the dinner was simple, direct and unaffected.

Sir Spencer Wells looks like a clergyman with a comfortable living, a retired haberdasher, or an easy going old family doctor; anything, in fact, rather than the greatest living abdominal surgeon. His speech in response to the toast that called him to his feet was unworthy of his reputation.

Sir William MacCormack is a Hercules in build, and reminds one somewhat of Dr. Wm. A. Hammond. He has a pleasant half humorous address and made a clever little speech at the closing meeting of the congress.

One of the most interesting figures at the meeting was Mr. Victor Horsley. Everyone was anxious to see the man whose exploits in cerebro-spinal surgery had attracted so much remark within the last two years. He is a thoughtful looking young man, with deep-set eyes, and dark hair and moustache. In conversation he is very agreeable, and his quiet and modest demeanor at the discussion on cerebral localization secured him the careful attention of all present.

Dr. Ferrier likewise made a good impression. Everyone knew that he had, so far as English medicine is con-

cerned, created the science of cerebral localization. His remarks were brief and sensible.

His figure is rather below than above the medium size, and with his well trimmed moustache and side whiskers, he reminded one more of an active life insurance agent than of a great physiological experimenter.

Among the Americans of note, Senn of Milwaukee attracted most notice. His earnest and somewhat robust style of speaking seemed to have a disconcerting effect upon the Boston-Philadelphia combination which engineered the Congress; and after his speech on abdominal surgery at the general meeting on Tuesday evening, it was freely reported as the opinion of some of the prominent members, that Senn was a "dead duck." But in another year these gentlemen will probably change their views. Nicholas Senn's head is a pretty large one, and the character of the work he has done hitherto is sufficient evidence of his capacity.

The address of the President, Dr. Billings, was, as anticipated, scholarly and full of meat. It was listened to by a brilliant assembly of both sexes, many of whom were doubtless attracted by the reception which followed. But every one who heard the address was well repaid for the time and attention given to it. After the address, a vote of thanks was proposed in a graceful speech by Dr. Kinloch, of Charleston, and then the Congress was declared adjourned.

The reception at the Army Medical Museum was a brilliant affair, the guests being received by Dr. and Mrs. Billings, Prof. Von Esmarch and the Princess of Schleswig-Holstein, his wife, Dr. and Mrs. Busey, Mrs. Magruder and other ladies. The main halls of the library and museum were crowded for nearly three hours, and amid the inspiring strains of music and the inspiring influence of punch, farewells were exchanged until the next meeting in 1892.

One of the most pleasant memories connected with the meeting was the reception by President and Mrs. Cleveland, on Wednesday afternoon. The hearty manner in which the President grasped the hands of his guests, and the superb grace and beauty of Mrs.

Cleveland captivated every one who had the good fortune to be present.

Dr. E. Carroll Morgan gave an enjoyable reception to the members of the Laryngological Association on Thursday, and Mrs. Billings entertained the ladies who accompanied the members of the Congress at lunch on Wednesday afternoon, just preceding Mrs. Cleveland's reception. These two entertainments were among the most recherche affairs of the week.

Altogether, the Congress must be pronounced a success. There were some things said and done that had better been left unsaid and undone; but, on the whole, the heartburnings will probably not last long. Those who hoped or feared that the Congress would injure the American Medical Association may dismiss such hopes or fears, for each of these great organizations will pursue its own way and work to the end of increasing the fair fame of American medicine and surgery.

G. H. R.

## HOSPITAL NOTES.

### MEDICO-CHIRURGICAL COLLEGE.

Probably Garretson does more deep nerve cutting than any other surgeon in the country, and the results are uniformly successful. A few days ago he removed the superior maxillary nerve at its exit through the foramen rotundum. This is the eighth time within six months that he has cut off one or another of the cranial nerves at the point of its escape from the brain. These are operations eminently requiring complete mastery of the *tactus eruditus*.

**AORTIC ANEURISM.**—Mr. —, aged 45, an Irish blacksmith, had been suffering for a year from dyspnoea, which was gradually growing worse. Some two months ago he applied to Dr. Garretson for relief. The patient's breathing was then extremely difficult, and at times he had exacerbations, so to speak, of the trouble, to the extent of falling to the floor helpless and unconscious in the struggle for breath. Dr. Garretson, after the most careful examinations, was unable to find evidences of either an aneurism or a mediastinal tumor, and finally concluded that the

trouble might arise from a hypertrophied condition of the mucous membrane lining the larynx and the adjacent parts.

He therefore advised tracheotomy as the only possible means of prolonging the man's life, as it seemed that he must certainly soon succumb to one of the attacks of increased dyspnoea. The patient having consented, on Sept. 8th the operation was performed.

The insertion of a tube, however, did not relieve the man's breathing; and it then became evident that the difficulty was below the tracheal opening. The patient, after three days more of struggling for breath, died of apnoea in one of his attacks.

At the autopsy it was found that the whole of the arch of the aorta was converted into a huge, irregular shaped aneurism, fully six inches in diameter. Three large, more or less organized clots, were seen at different parts of the aneurism. One of them in particular was a spindle-shaped clot, extending from inside the left ventricle, having the aortic valves close on it at each beat, some five or six inches along the posterior wall of the aorta, and was two inches in diameter at the thickest part. From this clot a small branch extended several inches up the innominate and out the subclavian.

The heart had undergone fatty degeneration, and the left ventricle was much hypertrophied.

Dr. Garretson discussed with the class the obscurity in diagnosis, as regard was had to the recognition of the aneurism shown by the autopsy; the obscurity doubtless existing in the extensive clots found—no sign of a bruit having been present.

The patient's breathing had been entirely diaphragmatic; adhesions throughout the whole circumference of the lungs having prevented any movement of the thorax.

The specimen is in the museum of the Medico-Chirurgical College, and the case was offered by the lecturer as one of the most interesting and instructive that he had ever seen.

For two months preceding Sept. 15, Mr. —, a patient of Dr. Garretson's, had been wearing an interdental splint as a support to his lower jaw, the right

half of which was undergoing necrosis. But, as the primary bone was dying and discharging, giving the man almost constant pain, new bone was forming under the periosteum around the diseased bone. Dr. Garretson, having decided that the new jaw was strong enough to bear an operation, determined to remove at once all the disturbing element, and thus hasten a cure.

An incision three inches long was made along the lower border of the jaw, and the flap dissected up. With the surgical engine, he quickly and easily bored a hole through the enveloping new bone, and from within its embrace removed all that was left of the necrosing structure.

**HEMORRHOIDS IN THE FEMALE.**—In cases of hemorrhoids in the female, examine to see if the uterus is not retroverted, thus obstructing the hemorrhoidal veins. This is the most common cause of hemorrhoids in woman.

—Montgomery.

**EXCEPTIONAL EPILEPSY.**—Waugh exhibited at his clinic a case of epilepsy which had two rather uncommon features: one was that the patient does not become unconscious during the attack; the other, that the convulsion is on one side only. The patient was a hard-drinking man of fifty, and the convulsions were of but one year's standing, with the cause obscure. Pending a thorough examination as to the cause, the bromide treatment was given.

**THE UTERUS IN EPILEPSY.**—Speaking of the uterus as an exciting cause of epileptic attacks, Waugh says that in one case he noticed on the os uteri a small red spot. Upon his touching this spot with a probe, the woman went into a violent convulsion. He immediately snipped out with a pair of scissors this reddened portion, and the patient has never since had an attack.

**CIGARETTE-SMOKING A CAUSE OF LARYNGITIS.**—A common cause of chronic laryngitis of an obstinate form is excessive cigarette-smoking. The variety is called *hypertrophic chondritis vocalis*.

—Barton.

**PAPILLOMATA ON THE VOCAL CORDS.**—Following a chronic laryngitis, we not unfrequently find papillomata grow-

ing on the vocal cords. If these are large, remove a small piece each time, and cauterize the fresh surface with acid nitrate of mercury, one to eleven.

—Barton.

**HOW TO OPERATE ON THE VOCAL CORDS.**—In making an application to the vocal cords, in order to avoid what is sometimes a dangerous spasm of the glottis, it is well to spray rhigolene for a few minutes outside the neck, over the insertion of the recurrent laryngeal nerve; meanwhile having the patient hold bits of ice in his mouth.

—Barton.

**VERY HIGH STRUNG.**—In the course of a lecture on "Diatheses," Waugh related a case of extraordinary nervous sensibility happening in his practice. The patient was a boy of ten, whose finger-nails were so sensitive that, immediately upon cutting them, a soothing ointment must be applied, and the fingers kept wrapped in cotton for two days.

#### JEFFERSON COLLEGE.

**GOOD DRESSINGS.**—For dressing small wounds it is well to have on your shelf a bottle of iodoform and collodion. After cleansing and drying the wound, it is painted with the mixture; and then, hermetically sealed, healing rapidly takes place.

As a dressing for larger wounds, it is well to keep on hand prepared gauze. You can make this by getting from the store as much cheesecloth as you wish, boiling it in water in which some soda has been dissolved, and afterwards put away in an air-tight jar. It is also well to have a jar of bichloride solution of a strength of from 5000 to 50000. With this solution the wound should be washed, and the gauze saturated with it before being applied.

HEARN.

#### ORTHOPÆDIC HOSPITAL.

**AMPUTATION OF THIGH.**—A few days since Goodman amputated the thigh of a boy, ten years old, for necrosis of the knee-joint, of a scrofulous origin.

**SAD RESULT OF GONORRHOEA.**—There is in the same hospital a case of ankylosis of the whole spine, due to gonorrheal rheumatism. The patient is receiving as treatment deep massage and large doses of iodide of potash.

## WILL'S EYE HOSPITAL.

**A SINGULAR CATARACT.**—Goodman operated on a case in which the anterior capsule had undergone calcareous degeneration. Upon breaking the capsule the lens flowed out as a milky fluid; and by the most careful search no nucleus could be found.

**A NEAT PLASTIC.**—Goodman has in the hospital a patient on whom he performed a neat plastic operation. She had an epithelioma as large as a silver dollar, extending up the lower eyelid close to the free edge of the tarsal cartilage. The growth was removed, and by an ingenious method he secured flap enough to cover the raw surface.

## PHILADELPHIA HOSPITAL.

**SPONTANEOUS COAGULATION IN CHOLERA INFANTUM.**—As an evidence of how the blood may be depleted of its fluid constituents by the profuse diarrhoea of cholera infantum, an autopsy at the hospital showed that the immediate cause of death in a case of this kind had been a clot in one of the lateral cerebral sinuses—the result of spontaneous coagulation.

**DISINFECTION IN CHOLERA INFANTUM.**—The napkins from children afflicted with cholera infantum are disinfected by being boiled and afterwards dipped in a weak solution of bichloride of mercury.

**ANTIPYRINE FOR BABIES.**—For pain and fretfulness in nurslings it has been the custom to give antipyrine in doses ranging from gr.  $\frac{1}{4}$  to gr. j. Opium has been given only a few times, as the other has proved quite satisfactory.

**ANEURISM OF THE INNOMINATE.**—At the Medical Clinic on September 15th, there was exhibited a most interesting case of aneurism of the innominate.

The patient, a boatman of forty-nine years of age, had been treated for two years for neuralgic pains in the right shoulder and arm; and, during the nine months preceding his admission to the hospital, he had suffered considerably from dysphagia and dyspnoea.

The true cause of his trouble was not suspected until two months ago, when a tumor about three-quarters of an inch in diameter suddenly made its appearance in the center of the manubrium.

Having once made its way through the bone the aneurism continued rapidly to absorb the bone until now fully the superior half of the sternum has disappeared along with the cartilages and ribs attached to that part of the sternum as far as from three to five inches to the right of that bone.

The appearance now presented is that of a tumor of an irregularly circular shape, some six inches in diameter, and four deep at the middle point. Not the least interesting feature is a diverticulum, three inches long and an inch and a half in diameter, extending from the main tumor in the direction of the common carotid, but *over* the clavicle.

The right radial pulse is much weaker and more compressible than the left. On account of the difficulty in breathing, the man's favorite position is sitting on the edge of the bed with his head leaning forward on the back of a chair. Among other reasons for diagnosing the aneurism as one of the innominate is the fact that the heart is displaced only one interspace downward and not at all outward.

**THE ANTERIOR FONTANELLE** in young children is a convenient and tolerably accurate means of estimating the amount of blood in the body. If the finger find a considerable depression, the quantity of blood is below normal; but if the skin of the fontanelle is on a level with that surrounding, the blood is all right so far as quantity is concerned.

**TUBERCULOUS KIDNEY—DOUBLE URETER.**—Two kidneys were shown from the same subject, one of which was tuberculous, and was marked by a number of cavities, several of which were half an inch in diameter. The other kidney was interesting by reason of having two ureters, each beginning at the pelvis, one and one-half inches apart, they joined in a common ureter three inches from the entrance to the bladder.

**ATLO-AXOID INFLAMMATION.**—At the surgical clinic a case was shown of this rather exceptional trouble. Three months before, the patient, a woman, had fallen backward, striking her head severely on the floor. Two or three days afterward pain and stiffness followed, and, growing worse, she finally came to the hospital. Here inflamma-

tion of the atlo-axoid articulation was diagnosed, and the woman was put on her back in bed, with a sand-bag on either side of her head to hold it in position. In these cases healing is both slow and uncertain, requiring from three to nine months. Sometimes, too, inflammation involves the transverse ligament, a movement of the head or body displaces the odontoid process backward, and death follows as quick as by a stroke of lightning. Frequently an abscess forms, determining forwards as a retro-pharyngeal abscess, or backward or downward. If life is spared, there is generally ankylosis of the joint.

**TREPHINING FOR EPILEPSY.**—Lately there have been performed two operations at the Philadelphia Hospital, and one at the Orthopædic, of trephining for epilepsy.

These cases of epilepsy were of the Jacksonian character, and by the manifestations of the trouble, the lesion was in each instance located on either side of the upper part of the left fissure of Rolando. The button of bone was in each case replaced and united without any trouble to the surrounding bone. In each case, too, most marked benefit followed the operation; in one an absolute cure resulting.

#### OBSTETRICAL SOCIETY OF PHILADELPHIA.

*Thursday, September 6th, 1888.*

J. C. DaCOSTA, M.D., in the Chair.

DR. WM. GOODELL read a paper entitled "A Year's Work in Oophorectomy."

During the year 1887, he had had nineteen cases with one death; but including the cases he had since had there was only one fatal result in twenty-nine cases. The cause of death in this fatal case was uræmic coma from suppression of urine. How far the administration of ether was to be blamed for this renal complication he was not prepared to say, but he was inclined to think that chloroform was not so liable to cause congestion of the kidneys. The operation was performed for dis-

eased ovaries and tubes, which were greatly crippling her.

The eighteen successful cases were performed for the following reasons and with the following results:

Uterine fibroids cured 5, improved 1.

Menorrhagia and ovaralgia cured 2, improved 1.

Ovaralgia cured 3, improved 1.

Epilepsy improved 1.

Hystero-neurosis cured 1.

Insanity unimproved 2.

Pseudo-muscular hypertrophy unimproved 1.

In his experience the removal of the ovaries for uterine fibroids is almost always followed by a cure, that is to say menstruation ceases, the tumor rapidly lessens in size and no further inconvenience results from bulk pressure.

Of the three cases of menorrhagia associated with ovaralgia, the lack of complete success in one was due to the fact that only one ovary could be removed. The other ovary was so matted in organized exudation as not to be distinguishable.

The failure in one of the cases of ovaralgia was due to the persistence of menstruation after a thorough extirpation of both ovaries. This is a very rare result, but it will occasionally happen. Menstruation usually ceases in these cases after the lapse of a few months.

In the case in which the ovaries were removed for epilepsy, the result has not thus far been a cure, but the attacks come at longer intervals. Hardly time enough has elapsed for the woman to reap the full benefit of the operation, for she still has regular catamenial moulins, accompanied by bloody expectoration.

Time enough has not yet elapsed to decide whether the two insane patients will be improved or be cured by the operation. Each one was an invalid, and each one became physically well, but not mentally so. In Dr. Goodell's experience, which has not been a small one, those cases which exhibit aberration of intellect only during the menstrual periods will almost always be cured by the removal of the ovaries. But cases of insanity, in which the hallucinations are continuous, yet much exaggerated

at the catamenial periods, are by no means so likely to be cured by the operation, although they are generally very much improved. In any case about two years time must elapse before the nerve perturbations of this artificial change of life wholly disappear, and a cure should not be expected before that lapse of time. What is true in mental cases, and in purely nervous ones, is also true in a measure when even coarse lesions of the ovary are found. Hence the surgeon must not look for full results, or for complete freedom from groin-aches and pelvic pains, directly after the removal of even diseased ovaries and tubes. He must wait patiently for the ovarian nismus or habit to cease, until, in fact, the menopause has been wholly and fully established in every way.

In the foregoing nineteen cases, the spray was not used, but every other antiseptic detail was carefully carried out. The pedicle was tied with silk; the wound was closed by the same material, and dressed with gauze dipt in a glycerole of carbolic acid. Drainage was employed but once, and that in the fatal case; but this had nothing to do with the issue. Eleven of the cases were treated at his private infirmary, seven at the Hospital of the University of Penn., and one at the patients own home.

DR. H. A. KELLY liked the moderate tone of the paper just read. He believed that here, as in other fields of work, we must be often satisfied with relative results. He liked the term "Ovaralgia" now better than he once did. Until we are better able to differentiate the exact nature of the lesion in some of these cases, he thought the term "ovaralgia" used generically is a good one.

He had a rare case of salaam convulsions which had been treated for a long time. He had been called in to decide the advisability of an operation and had refused to remove the ovaries. Two years later the ovaries had been removed and the patient cured. There did not seem to be any distinct connection between the pelvic and general condition.

DR. M. PRICE asked Dr. Goodell if in these operations he had ever noticed

in ligation any change in the number of the heart beats? He had several patients, in whom, on the evening of day of operation he had found the pulse as low as 48. He had noticed somewhere that an operator found a drop of the pulse from 80 to 35 on ligating the ovarian nerve. Since then he had had the pulse beats counted on a number of patients at the time of the ligation and had found a drop of only 4 or 5 beats at most.

DR. J. PRICE said that Dr. Johnston, of Danville, Ky., had dwelt on the matter of slowing of the pulse very fully.

He thought that the explanation of continued pain after an operation was to be found in the adhesions of the intestines, etc. Some of his most satisfactory results had been obtained in cases of extensive adhesions. In a recently reported case the patient had complained of agonizing abdominal pain, an adherent omentum and a knuckle of intestine had been separated and complete relief obtained. He had operated on a number of cases where the only lesion found was a general adhesion of the whole mass of intestines. He had thoroughly separated them and had obtained most satisfactory results. Mr. Tait has repeatedly re-operated to free adhesions. He felt that operation for nervous disturbances was of very doubtful benefit and he never operated unless he found actual disease. He preferred handing the patient over to others.

DR. M. PRICE related a case in which the whole trouble was due to adhesions. It was supposed to be a case of gall-stones. No disease and no gall-stones were found, but the intestines were matted together, the adhesions were released and no pain was felt afterwards.

DR. JOSEPH HOFFMAN. Dr. Price has referred to lowering of the heart beat after application of the ligature. In a case of my own the pulse, which on the day of operation, before ether had been given was 120, had gone down in a few hours after the operation to 58. After ten days it crept up to 80. This low register of 56 to 58 was sustained even in spite of the temperature being 101° or 102°.

DR. B. C. HIRST had operated on a case in which a small portion of one ovary was left. The case had ceased menstruating even in spite of the part left behind. A stitch had passed through the remaining piece.

DR. W. S. STEWART wished to know the effect of removal of both ovaries on menstruation, if at the time it should occur, there were any evidences, such as acceleration of the pulse, etc., as seen at the menopause?

DR. WM. GOODELL had referred to the point suggested by Dr. Stewart in his paper and he said that just such symptoms appeared in these cases as appeared after the natural menopause. The full results were not obtained until after these ceased. He had never noticed a fall in the pulse beats as referred to, but he had often seen serious collapse follow the pinching of the ovary. He had seen the pulse fall to 97° and in one case below this. He thought that a counterfeited aneurism was by no means an infrequent symptom of ovarian disease. He had had a patient from a distance suffering from ovarian enlargement, aortic pulsations and other nervous disturbances, for which he prescribed. Afterwards a local surgeon insisted that she had aneurism. A second examination convinced him that such was not the case. This was afterwards made evident by her passing through an exceedingly difficult confinement safely. There are two conditions in which he was willing to operate for the removal of the ovaries, although he found no disease. One is *epilepsy*, the other is *insanity*, for in these cases a woman should never conceive. He believed that the State should interfere to prevent men and women who suffer from epilepsy or from insanity from getting married. Indeed he is not sure that the day may not come when by act of legislature an insane man will be castrated and an insane woman will have her ovaries removed. He has had a good deal of experience with removal of ovaries for insanity and has had some happy results; on the other hand he had been disappointed at times. In cases of epilepsy he had not had so much experience. He wished that gentlemen who have had such cases would report them.

DR. C. M. WILSON had had three cases such as spoken of by Dr. Goodell. In two the result was negative. One patient was apparently benefited for some months, but recent reports say that there is a gradual relapse into the former condition.

DR. H. A. KELLY had, about three years ago, operated on a girl with a brachial paresis resulting from infantile palsy, with, also, epileptic attacks pre- and post-menstrual in character. For some months there was no improvement; but lately she has become better.

DR. KERLIN had remarked to him that if in a good many of these cases of hopeless idiots, operations were performed removing the respective organs during the period of active growth, they would not develop some of their worse features and would be more easily managed.

DR. J. M. BALDY had a case which at the time of operation looked like true epilepsy. There were excessive pain, vaginismus, and other symptoms. The pain was relieved, but not the vaginismus, for which a subsequent operation was performed. The epileptic attacks had continued. They were, however, becoming much less frequent than formerly. Some two years had now elapsed.

DR. J. PRICE operated on a patient with double pyosalpinx and epilepsy at the menstrual period, and at no other time. The recovery was complete and the relief absolute. Some ten months after she went to another institute complaining of pain and was again opened. He wished to know whether or not in these cases convulsions come on during the period in which the patient is in bed after operation.

DR. JOSEPH HOFFMAN had a case of three months' standing, which suffered from hæmato-salpinx and suppurating appendix. The patient had been having epileptic attacks. She has been entirely free from them since the operation.

DR. W. S. STEWART said that he did not think that the ovaries should be removed in all cases of epilepsy, as suggested by Dr. Goodell. He had an epileptic patient whom he had confined several times, and whose children show-

ed nothing wrong about the intellectual development.

He had removed the ovaries of a woman suffering from epileptic seizures, and she had received no benefit from the operation. She is now in an insane asylum.

DR. GOODELL said that there was no disease so likely to be inherited as epilepsy and insanity. If Dr. Stewart lived long enough he would find the children referred to develop the disease.

DR. H. A. KELLY reported a case of *Cæsarean Section*.

He operated April 17th of this year, delivering a living child and saving the life of the mother.

The patient, a slight woman, 4 feet 4 inches in height, had been in labor two weeks, her physician, Dr. Ireland, having watched by her bedside constantly for nine days previous to the operation. The waters ruptured four days before operation.

The estimated actual conjugate diameter was two and a quarter inches, although the pelvis was so choked by general œdema and hard cellutic masses that it was impossible to recognize any structures with satisfaction, much less reach the presenting part of the child.

The patient's pulse at the time of operation was 142. The operation lasted thirty-five minutes. The after condition and convalescence was one of comfort and rapid recovery.

This makes the ninth case operated on in Philadelphia, the first being by Prof. Gibson in 1835, the historic case of Mrs. Reybold.

Dr. Kelly stated that he had since that time also operated upon another case for a relative indication, in preference to performing craniotomy upon a living child, with the result of saving both mother and child; this question, however, of the relative indication, was one of such importance, deserving such careful consideration, that he would reserve it for a more elaborately prepared paper at a future date.

DR. JOSEPH PRICE read a paper on *The Abuse of Cæsarean Section*.

On the legitimacy of the Cæsarean section, there cannot be now, under certain restrictions and limitations, a question. In extreme cases, where

hasty operation is necessary in order to save the life of the mother, where there is impaction or where there is a tumor blocking up the uterine or the vaginal outlet, discussion or hesitation has little place, and he can operate best who has all resources at command and acts without hesitation.

The real points for discussion of the true necessity of the Cæsarean section, in order to terminate a labor, with greatest safety, first to the mother, then to the child, are: first, "*The degree of contraction in the pelvis*;" second, "*The advancement of pregnancy*;" third, "*The chances for the induction of premature labor*." As to the first: As an epitome of the latest generally received opinion, we have the statement of Craig Smith: "The operation [Cæsarean section] is said to be justifiable when the contraction is so great that we cannot expect to deliver the fetus per naturales vias, with or without embryotomy, and save the mother. The degree of contraction is generally stated as one and a half inches and below. But in cases in which much distortion exists we may have an upward limit of two inches."

Here, then, is a plain expression of conservative opinion as to the degree of deformity necessitating or justifying the operation. "As to the induction of premature labor," says Playfair, "there are few practitioners who would not deem it their duty to spare the mother the dangers of the Cæsarean section," this being especially true since "there is no amount of deformity, however great, in which we could not succeed in bringing on miscarriage by some of the numerous means at our disposal."

The time at which premature labor should be brought on varies, of course, with the degree of deformity of the pelvis; the tables of direction have been admirably constructed by Kiwisch. Briefly, the period for induction of labor lies between the thirtieth and thirty-sixth week, and the corresponding sacro-pelvic diameters vary between two inches and six lines and three inches and five or six lines.

Here, then, naturally follows a discussion of the means for inducing premature labor. Of the many methods proposed at various times, the one

seemingly the best is the use of the soft catheter. Its introduction well into the uterus for a distance of six or seven inches is an almost certain means of speedily producing labor pains safely.

I consider the British rule, that Cæsarean section should never be an operation of election, but one of necessity, in general terms, as the safeguard of puerperal women. Once establish the precedent that the Cæsarean section is an elective procedure in obstetrics, and thereby lay down also the principle that abdomino-uterine section is a safer procedure than the introduction of a soft catheter into the uterus before full term, the way is laid open to every aspirant for obstetric fame, who is the fortunate possessor of a knife, to find cases for his zeal at every court and corner in the city, if perchance he can of himself persuade the parturient woman of the necessity of delivery by "*the new natural method of delivery.*"

An axiom as to the operation is laid down by Lusk: "The precise limits at which the dangers of delivery through the pelvis rise to the level, or exceed those from Cæsarean section, is not easy to determine. It depends partly upon the size and ossification of the child's head, and largely upon the experience and dexterity of the operator." The converse of this proposition is true also. The greater the experience and the more careful the observation of the operator, the less frequently will he be led to resort to Cæsarean section, if he hold in mind that it is an operation of necessity, not of election.

Two cases will illustrate the dangers here referred to, and the justness of these forebodings.

*Case I.*—A woman, already delivered of a living child, yet living at four years. Three other deliveries at term with the forceps. All of these children dead. No attempt at premature labor. In the fifth pregnancy she is decided upon as a case for Cæsarean section. She passes into the hands of another attendant, who, after careful pelvic measurements with a consultant, decides on premature labor. The woman delivers herself without instruments of a child, whose head has a biparietal diameter of three and one-fourth inches, the period of gestation being eight and

a half months. The previous measurements of the pelvis, had decided upon an antero-posterior diameter of three and a half inches.

*Case II.*—Is an actual operation. A woman in third pregnancy. First child delivered after thirty hours; labor with instruments, dying soon after birth. Second pregnancy: She delivers herself of a child of normal proportions at full term, without instruments. The child yet living. Third pregnancy: Cæsarean section. Recovery after protracted convalescence. Child still living.

Here are lessons full of instruction. What do they teach?

DR. M. PRICE thought that the duration of labor had nothing to do with the choice of Cæsarean section. He had delivered a woman two weeks since who had been in labor seven days. It was an occipito-posterior position, and the cervix did not dilate more than enough to permit the introduction of two fingers. He introduced his hand, dilated the os and applied Simpson's forceps. The delivery occupied an hour and a half; but the woman made a good recovery. Had the case been delayed a few days longer, there might have been a necessity for Cæsarean section. Where there is an inflammatory and œdematous condition of the pelvis, he thought there should be some forcible measures adopted for the delivery of the patient.

DR. WM. GOODELL thought that the title of Dr. Price's paper was not a fortunate one: for the gentlemen who are called upon to perform Cæsarean section are usually not the attending physicians, and they have had nothing to do with the previous medical attendance on the patient. He believed in the induction of premature labor, and would do it in preference to the performance of Cæsarean section. But often the patient herself will not submit to the induction of labor. Dr. Price would probably admit, one day, into the "Retreat" an Irish woman who has had the most frightful labors, and who had persistently refused, from conscientious motives, to permit the induction of labor. He could conceive of cases where it would be better to perform Cæsarean section, although he

had never as yet done so. Probably in some of the cases in which he had formerly opened the head he would now do the Cæsarean section. He thought a woman might go on safely in labor for an indefinite time, so long as the bag of waters had not ruptured, with very little danger to herself.

DR. H. A. KELLY remarked that the bag of waters had ruptured four days before the operation. The pains had been very hard before this time, and did not change in character afterwards, although the woman soon dropped into collapse. The pelvis was so choked by a hard cellulitic mass that it would have been impossible to dilate anything or reach anything above the mass. The second paper evidently referred to his case performed on a relative indication in preference to craniotomy. That case he had not yet reported, reserving it for a full, careful discussion. Where any such garbled, distorted particulars had been hunted out, he did not know, nor could he reply to criticisms offered in such a tone. His profession was his life; and he came here to impart, and still more to receive information in a spirit becoming the dignity of the profession, and he would not make life unhappy by taking part in any miserable bickering.

DR. J. PRICE said that in a long experience in the Obstetric Department of the Phila. Dispensary, he had numerous cases of deformed pelvis and illy developed women, some of them very young. He would simply call attention to two typical cases. No. 1. A case in which Dr. Eliot Richardson had five times done craniotomy or complete evisceration. This woman applied in her sixth pregnancy to the Phila. Dispensary, and was assigned to Dr. Joseph Fox for induced labor; in a period of five years he had induced labor three times, in this case, delivering by forceps and saving two children, one still born. Case No. 2. Also a Dispensary case, had in her five previous labors the children destroyed, the sixth was provoked at eight months, two weeks, and she was delivered with forceps of a fine large male child. In a short experience at Preston Retreat he had dealt with two cases of greatly contracted pelvis, in both of which Dr. Goodell had twice

or thrice induced labor, delivering living children. Recently two cases were sent in for induced labor or Cæsarean section. The consultants determined on the induction of labor. Both cases terminated favorably with living children; one of them was a forceps delivery, the other normal. These are only typical cases; but few of the many he could cite in his own experience.

If Dr. Kelly was satisfied that the last case given in the paper was his second Cæsarean section, he was sure he was welcome to his knowledge, as no one else would wish to lay claim to it.

DR. J. PRICE exhibited a specimen of a small male foetus, at about the third month, removed from a case of extra-uterine pregnancy. Patient healthy and twice married. There had been numerous attacks of pain. Recovery from operation was rapid. The following week he did an abdominal section on a woman who was unconscious and removed an extra-uterine pregnancy. She died 26 hours later. This was the sixth case of extra-uterine pregnancy which had developed in his practice in four weeks. One case he went into the country to operate, and found the patient dead when he arrived. Dr. Formad told him that this was a very common result in his experience as coroner's physician.

He also showed a dermoid cyst, removed from a woman who had suffered from chronic peritonitis for years. Her physician had given her as much as a grain of morphine hypodermically and had sat up all night etherizing her, to relieve her pain. She was greatly emaciated, with a rapid feeble pulse, high temperature, and had been in bed for six weeks. Whole tumor enucleated, no ligatures required. Intestines separated and irrigated—glass drainage. This is the ninth day and she is rapidly convalescing.

J. M. BALDY, *Secretary.*

## REVIEWS AND BOOK NOTICES.

THERAPEUTICS: ITS PRINCIPLES AND PRACTICE. By H. C. WOOD, M.D., LL.D., etc. Seventh edition. Rearranged, rewritten and enlarged. Philadelphia, J. B. Lippincott Company. 1888. Pp. 908. Price, \$6.00.

That notwithstanding the many competitors to be found in the market, a work on therapeutics should reach its seventh edition in thirteen years, is evidence of the high appreciation in which it is held. During the three years which have elapsed since the appearance of the sixth edition, Dr. Wood tells us he has carefully studied nearly six hundred memoirs. Remedial measures other than drugs have grown in favor, and this department has been transferred to the first part of the book, and its scope extended so as to take into account massage, metallotherapy, diet, etc. The new drugs have received due attention, and the articles upon the old ones have been in many cases rewritten.

A new classification has been adopted, which the author believes to be more simple and natural than that previously employed.

Dr. Wood's book is one which requires more study than some of its contemporaries, but it is better worth studying. It is not so pointed in its therapeutic precepts, but it is oftener correct. The author is a man too decided in his convictions to be capable of assuming the judicial impartiality at all times, and it will generally be found that his own results carry conviction with him far more readily than the same amount of evidence tendered by other and equally authoritative observers. Taken all in all, however, we have little hesitation in pronouncing this the most reliable work on therapeutics in the English language, and we cheerfully recommend it to those of our readers who desire to be versed in recent therapy.

### ABSTRACTS.

**GELSEMIUM.**—GARLAND, in the *Boston Med. and Surg. Journal*, gives his experience with this potent drug. In the paroxysms of hysteria he recommends gelsemium above all other agents, pushing it until diplopia and ptosis appear. Catarrhal headaches and those which accompany dysmenorrhœa and nervous debility from over-work are amenable to gelsemium. Neuralgias of the superior branch of

the fifth nerve are also relieved by this drug, if not due to inflammation. The headaches of Bright's disease are also mitigated by gelsemium; but not bilious or sick-headaches. In the early stage of acute bronchitis, when the cough is bad, the tubes dry and there is pain in the chest, gelsemium relieves the distress, starts the bronchial secretion and lessens tension. This drug is an unfailing diaphoretic. Follicular tonsillitis, with acute febrile symptoms, is quickly relieved by this diaphoresis; as is also acute myalgia. Gelsemium will allay excitable reflexes, lessen the nervousness of passive cerebral congestion, and is said to give good results in acute meningitis.

McKay recommends it in ague, giving  $\frac{1}{4}$  to  $\frac{1}{2}$  drop doses of the fluid extract every twenty minutes, commencing three hours before the expected chill.

Davis gives small doses to relax a rigid os, and for after-pains.

Chamberlain gives it with quinine to prevent ringing in the ears.

The dose for neuralgias is three to five drops of the fluid extract every half hour, or less, according to the pain.

To produce sweating, one drop every half hour is sufficient. One drop every hour will relieve bronchitis. In case an over dose is taken, morphine is the antagonist; also, digitalis, ammonia, and alcohol.

The advantages of gelsemium are its agreeable taste, its non-irritating quality, freedom from depressing after-effects, safety in heart diseases when used in ordinary doses; it does not create a habit, and the toxic symptoms are very striking, appear early and are readily obviated.

In moderate doses it slows the heart, lowers muscular force and sensibility, causes ptosis and dilated pupils, with diaphoresis. These symptoms should be produced in order to relieve neuralgic pain.

In toxic doses it produces vertigo, diplopia, paralysis of third nerve, labored respiration, slow and feeble heart, dropped jaw, staggering, extreme muscular weakness and anæsthesia, profuse diaphoresis, loss of articulation and death from paralysis of respiration. The temperature is lowered. The effects of a moderate dose pass off in three hours.